

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12790

CERTIFICATE OF DEATH

12799

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
c. LENGTH OF STAY IN 1b <b>50 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cheverly Prince Gen. Hospital</b>		d. STREET ADDRESS <b>9301 Duberry Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>H</b> Last <b>Aberts</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Oct., 1910</b>
9. AGE (In years lost birthday) <b>56</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Aberts</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Pyles</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>579 07 7050</b>	
17. INFORMANT <b>Gladys Aberts</b>		Address <b>Lanham, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma; right upper lobe.</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>was</del> <b>was</b> ) attended the deceased from <b>Sept. 28, 1967</b> , to <b>Sept. 28, 1967</b> , that (I) ( <del>was</del> <b>was</b> ) last saw the deceased alive on <b>Sept. 28, 1967</b> , and that death occurred at <b>4.00 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin S. Miller</b>		22b. DATE SIGNED <b>Sept. 28, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Benjamin Miller, M.D.</b>		22d. ADDRESS <b>3824-34th St. Mt. Rainier, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Clinton Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15730

CERTIFICATE OF STATE

Prince George's

Virginia

Prince George's

Landings

20 days

(Twenty)

9331 Property Avenue

Marine Corps, U.S. Hospital

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2000

2000

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10 Oct. 1910

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12791

CERTIFICATE OF DEATH

12800

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital, Glenn Dale, Md.</b>		e. STREET ADDRESS <b>419 Franklin Street, N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Conley</b> Middle <b>W.</b> Last <b>Alexander</b>		4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/24</b>
9. AGE (In years lost birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charlie Alexander</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Sloan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1943-1946</b>		16. SOCIAL SECURITY NO. <b>240-30-2798</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 years 5 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/7/67</b> , 19 <b>9/8</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/8</b> , 19 <b>67</b> , and that death occurred at <b>10:40</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>9/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>9-13-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shannon Memorial Cem. Landrum Md.</b>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <b>Johnson &amp; Denkin Funeral Home</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
ADDRESS <b>4804-Ca AVE NW</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>	

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10-10-80

TO: DIRECTOR, MASSACHUSETTS DEPARTMENT OF CORRECTIONS

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12792

CERTIFICATE OF DEATH

12801

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4608 Fordham Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Anderson</b> Last 4. DATE OF DEATH Month <b>Sept</b> Day <b>27</b> Year <b>1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Jan 1882</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Ellen R Rynn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Frank G Anderson</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Multiple pulmonary embolism with</b> <b>003.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary infarction of left upper lobe.</b> DUE TO (c) <b>Bilateral pleural effusion, 1000 cc each side.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9-16</b> , 19 <b>67</b> , to <b>9-27</b> , 19 <b>67</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>9-26</b> , 19 <b>67</b> , and that death occurred at <b>4:40 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>R.D. Bauer, M.D.</b>		22b. DATE SIGNED <b>9-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.D. Bauer, M.D.</b>		22d. ADDRESS <b>2513 Buck Lodge Rd. Adelphi Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Sept 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12793

12802

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>10 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>				d. STREET ADDRESS <u>6927 Nashville Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Magdalene Agatha Angerman</u>				4. DATE OF DEATH <u>Sep. 24</u> 19 <u>67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-94</u>	9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Wm. H. May</u>			14. MOTHER'S MAIDEN NAME <u>Laura L. Cheney (May)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Elizabeth Ladd</u> Address <u>6927 Nashville Rd., Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>731X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Fracture of right femoral head</u> DUE TO (c) <u>Pagets disease of bone</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>24 July</u> , 19 <u>67</u> , to <u>24 Sept.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>22 Sept.</u> , 19 <u>67</u> , and that death occurred at <u>11:20 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>Sept 24, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>AARON DEITZ</u>	
22d. ADDRESS <u>Prince Geo. Plaza, Hyattsville, Md.</u>				22e. REC'D BY REGISTRAR <u>[Signature]</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Sept 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>James Walter</u> ADDRESS <u>254 Carroll St NW</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

12508

CERTIFICATE OF DEATH

12508

Prince George

Mr.

Prince George

10 days

Hottelville

Leaham

Hottelville Nursing Home

633 Nashville St.

Magdalen A. Hagerman

288 28

F W

3-8-43

Home maker

Washington, D.C.

Wm. H. Hotel

Mrs. Elizabeth L. Channing (nee) 633 Nashville St.

Signature

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12794

Item #7 Film #G392 8/11/67 ph

## CERTIFICATE OF DEATH

12803

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY in 1b <b>1 mo. 18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>5404 Spring Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>E.</b> Last <b>Baldwin</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-01</b>		9. AGE (In years last birthday) <b>66</b> yrs.	10. IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Layer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Houses</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Long</b>				14. MOTHER'S MAIDEN NAME <b>Grace Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>705 09 7020</b>		17. INFORMANT <b>Edna M Baldwin</b> Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5721</b> DUE TO <b>Cardiorespiratory arrest see</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia BILATERAL de Fense</b> DUE TO <b>5 wks</b> (c) <b>Pleuritis sec. Resection of sigmoid colon</b> DUE TO <b>6 wks</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pleuritis sec. sigmoid diverticulitis 7 mons</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-16</b> , 19 <b>67</b> , to <b>9-3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-3</b> , 19 <b>67</b> and that death occurred at <b>5:30 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>George S. Banning, Jr.</b> M.D.				22b. DATE SIGNED <b>SEP 3-1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. George S. Banning, Jr.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Mechanicsville St Marys Md</b>	
24. FUNERAL DIRECTOR <b>F Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 8 1967</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12795

**CERTIFICATE OF DEATH**

12804

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>20 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>1005 Chillum Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>J.</u> Last <u>Baldwin</u>		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1906</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin J. Baldwin</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Rooney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-10-9739</u>	
17. INFORMANT <u>Mrs. Catherine C. Baldwin</u>		Address <u>above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> (Wife) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002.1</u> (b) <u>Pneumonia left lower lobe and pulmonary edema</u> DUE TO (c) <u>1 day</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary fibrosis and emphysema, Pulmonary tuberculosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <u>9-4</u> , 19 <u>67</u> to <u>9-23</u> , 19 <u>67</u> , that (b) (we) last saw the deceased alive on <u>9/23</u> , 19 <u>67</u> , and that death occurred at <u>6:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick Henry Wilhelm</u>		22b. DATE SIGNED <u>9/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick Henry Wilhelm</u>		22d. ADDRESS <u>6319 Landover Road; Cheverly, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Colmar Manor, Md.</u>
24. FUNERAL DIRECTOR <u>Home Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>			



12442

CERTIFICATE OF DEATH

TO HAVE IN FULL EFFECT, THE FOLLOWING CERTIFICATE OF DEATH MUST BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, IN THE CITY OF NEW YORK, IN THE MONTH OF MAY, 1961.

NAME OF DECEASED: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SEX: [illegible]  
AGE: [illegible]  
RACE: [illegible]  
RELIGION: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MARRIAGE: [illegible]  
SOURCES OF INFORMATION: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE OF ENTRY: [illegible]

1

Home 100, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12796

12805

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>1418 University Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>Edward</b> Last <b>Barbee</b>				4. DATE OF DEATH Month <b>9</b> Day <b>8</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-1911</b>		9. AGE (In years last birthday) <b>56</b> yrs.	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept Store</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lewis Edward Barbee</b>				14. MOTHER'S MAIDEN NAME <b>Geneva Cockrill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W W 11</b>		16. SOCIAL SECURITY NO. <b>579 01 3762</b>		17. INFORMANT Address <b>Nellie G Barbee Adelphi, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>443 X</b> DUE TO <b>Hypertensive cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>over 1 yr.</b> minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type) <b>John Kahoe, M.D.</b> <b>Riverdale, Md.</b>				22. DATE SIGNED <b>9-9-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12797

12806

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>FAIRFAX</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AF BASE</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>7708 RANDOM RUN LA APT 102</b>			
3. NAME OF DECEASED (Type or print) First <b>INFANT</b> Middle <b>—</b> Last <b>BISHOP</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 14 1967</b>	9. AGE (In years last birthday) <b>—</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hour <b>9</b> Min <b>31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGES</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BOYD W. BISHOP</b>				14. MOTHER'S MAIDEN NAME <b>TOBY FRANCES KESSLER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NA</b>		17. INFORMANT <b>FATHER</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory + Cardiac Arrest</b> <b>7735</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory Distress Syndrome</b> DUE TO (c) <b>Prematurity</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 HRS.</b> <b>10 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>14 Sept 1967</b> to <b>14 Sept 1967</b> that (I) <b>last</b> saw the deceased alive on <b>14 Sept 1967</b> , and that death occurred at <b>8:51 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Herrick J. Cohen</b> M.D.				ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>HERRICK J. COHEN, CAPT USAF MC</b>				22b. DATE SIGNED <b>14 Sept 67</b>			
22d. ADDRESS <b>USAF Hospital Andrews Andrews AFB, Wash DC 20331</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc. 3072 - 14 St. N.W. Wash, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

7-247279

UNITED STATES DEPARTMENT OF JUSTICE  
DIVISION OF INVESTIGATION

STATEMENT OF WITNESS

NAME OF WITNESS

ADDRESS OF WITNESS

DATE OF STATEMENT

TIME OF STATEMENT

PLACE OF STATEMENT

STATEMENT OF

TO

BY

DATE

TIME

PLACE

NO.

STATEMENT OF

TO

BY

DATE

TIME

PLACE

NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12798

CERTIFICATE OF DEATH

12807

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		
c. LENGTH OF STAY IN 1b <u>12 days</u>			d. STREET ADDRESS <u>Box 622</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Leo</u> Last <u>Bivins</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1967</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10/11/1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Richard Bivins</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hemsley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-9417</u>		17. INFORMANT <u>June Cooper -La Plata, Md. (Daughter)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>67</u> , to <u>9-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-25</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> P.M., from causes and on the date stated above.					
22a. SIGNATURE <u>Alfred R. Laperriere, M.D.</u>		22b. DATE SIGNED <u>9/26/1967</u>		22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPERRIERE</u>	
22d. ADDRESS <u>Clinton, Maryland</u>		22e. REC'D BY REGISTRAR <u>  </u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22g. DATE <u>SEP 29 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	
23d. LOCATION (City or Town) <u>La Plata, Md.</u>		23e. (County) <u>  </u>		23f. (State) <u>  </u>	
24. FUNERAL DIRECTOR <u>Arehart Funeral Home, Inc. -La Plata, Md.</u>		24a. ADDRESS <u>  </u>		24b. REC'D BY REGISTRAR <u>  </u>	
24c. REGISTRAR'S SIGNATURE <u>  </u>		24d. DATE <u>  </u>		24e. REGISTRAR'S SIGNATURE <u>  </u>	

UNITED STATES DEPARTMENT OF JUSTICE  
DIVISION OF INVESTIGATION  
WASHINGTON, D. C. 20535

1-28-67

MEMORANDUM FOR THE DIRECTOR

1-28-67

TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-15 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12808

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>2109 Iverson Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Reuben</b> Middle <b>Augustus</b> Last <b>Bogley Jr.</b>				4. DATE OF DEATH Month <b>9</b> Day <b>26</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-1903</b>		9. AGE (In years lost birthday) <b>63</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hotel Administration</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>Reuben A. Bogley Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Sallye C. Haas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret N. Bogley</b> Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self at home.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7:30pm</b> <b>9-26- 1967</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Basement of home</b>	
				20f. (City or town) <b>Same as #2</b> (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> M.D.				22. DATE SIGNED <b>9-27-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/29/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Prince Georges, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>SEP 29 1967</b> DATE		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12800

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #6 Film #G393 9/27/67 ph

CERTIFICATE OF DEATH

12809

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCES GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAPITOL HEIGHTS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCES GEORGES GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>821 58th AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MINNIE M. BOSWELL</b>		4. DATE OF DEATH Month Day Year <b>SEPTEMBER 15 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 17, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN SAGER</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ALBERT E. BOSWELL 2824 FOREST TERRACE</b>		Address <b>KENT VILLEGGE Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior choroidal Cordar -</u> DUE TO <u>Vascular Cerebral Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 years</u> (c) <u>10 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/13/67</u> , 19 <u>67</u> to <u>9/15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>67</u> , and that death occurred at <u>11:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William Brainin</u>		22b. DATE SIGNED <u>9/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		22d. ADDRESS <u>6124 Central Ave, Capitol Heights</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND PRINCE GEORGES Md.</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 18 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED OCTOBER 10 1950

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

TO THE DIRECTOR

AGRICULTURE

FROM THE DIRECTOR

UNITED STATES

DEPARTMENT

821 30TH AVENUE

NEW YORK, N. Y.

7

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OCTOBER 17, 1950

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10

AGRICULTURE

DEPARTMENT

UNITED STATES

DEPARTMENT

ALBERT E. JOHNSON, JR., DIRECTOR

RECEIVED OCTOBER 10 1950

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

TO THE DIRECTOR

FROM THE DIRECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>	
c. LENGTH OF STAY IN 1b <b>4</b> days		d. STREET ADDRESS <b>Rt. 3 Box 333</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isabella</b> Middle <b>Bowie</b> Last <b>Bowie</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 Aug. 1925</b>
9. AGE (In years lost birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>6</b> Days <b>6</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>House wife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Prince George Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Pinkney</b>		14. MOTHER'S MAIDEN NAME <b>Laura Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Bernard Johnson - same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident.</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Atherosclerotic Vascular Disease</b> (c) <b>and Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>9/21</b> , 19 <b>67</b> , to <b>9/24</b> , 19 <b>67</b> that <del>the</del> (we) last saw the deceased alive on <b>9/24</b> , 19 <b>67</b> , and that death occurred at <b>6:24</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Robert S. Burroughs</b>		22b. DATE SIGNED <b>Sept 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert S. Burroughs</b>		22d. ADDRESS <b>Box 57, Upper Marlboro Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brooks Church Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Willingham, P. Geo. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Martell Adams Aguasco, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>	

2-10

CERTIFICATE OF DEATH

Prison Hospital, Federal Penitentiary, Washington, D. C.

Prisoner of War, No. 100,000,000

Prisoner of War, No. 100,000,000

Prisoner of War, No. 100,000,000

Prisoner of War, No. 100,000,000

Prisoner of War, No. 100,000,000

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Prisoner of War, No. 100,000,000

Prisoner of War, No. 100,000,000

Prisoner of War, No. 100,000,000

2-10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12811

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George Hospital</b>				d. STREET ADDRESS <b>9017 Contee Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Allen</b> Last <b>Brazelton</b>				4. DATE OF DEATH Month <b>9</b> Day <b>2</b> Year <b>19 67</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18 1924</b>		9. AGE (In years lost birthday) yrs. <b>42</b>	10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>STATE OF ALABAMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DON HENRY BRAZELTON</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTOBEL MCKNIGHT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MR. GEORGE G. BRAZELTON, COLUMBIA, TENN.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>981X Gunshot wound of head</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7:45 am</b> <b>8 16 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bedroom of home</b>		20f. (City or town) (County) (State) <b>Same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale, Md.</b>		22. DATE SIGNED <b>9-3-67</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/6/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HUNTSVILLE, ALABAMA</b>	
24. FUNERAL DIRECTOR <b>William M. Hysong</b> ADDRESS <b>WASH., D.C.</b>				25a. REC'D BY REGISTRAR <b>SEP 5 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	
<b>HYSONG FUNERAL HOME - 1300 - N ST. N.W.</b>							



Department of Chemistry

Chicago, Illinois

June 10, 1954

Dear Sir:

I am very pleased to hear from you.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

I am sure you will find the enclosed of interest.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12803

12812

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>		d. STREET ADDRESS <b>4237 Grant St., N.E.</b>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b> First Middle Last <b>BRUNER</b>		4. DATE OF DEATH <b>Sept. 16 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>79</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Dorsey Holland</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles D. Bruner</b> Address <b>4237 Grant St., N.E.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 HRS.</b> <b>10 YRS.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-31</b> , 1967, to <b>9-16</b> , 1967, that (I) (we) last saw the deceased alive on <b>9-16</b> , 1967, and that death occurred at <b>6:30</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <b>W.B. Sheer</b>		22b. DATE SIGNED <b>9-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>		22d. ADDRESS <b>6400 MARLBORO PIKE S.E. WASH. D.C. 20028</b>	
23a. BURIAL, CREMATION, REMOVALS <b>BURIAL</b>	23b. DATE THEREOF <b>9/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Ceme.</b>	23d. LOCATION (City or Town) (County) (State) <b>Maryland</b>
24. FUNERAL DIRECTOR <b>John T. Sheer</b> ADDRESS <b>Stewart Funeral Home-4001 Benning Rd., N.E.</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



12

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

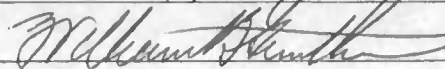

12804

CERTIFICATE OF DEATH

12813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLLEGE PARK</b>		c. LENGTH OF STAY in 1b <b>14 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9521 49th Place</b>		d. STREET ADDRESS <b>9521 49thPl</b>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>E.</b> Middle <b>Bussan</b> Last		4. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1910</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Bussan</b>	
14. MOTHER'S MAIDEN NAME <b>Caroline Schnerre</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>328-16-7078</b>		17. INFORMANT <b>Rosetta Bussan</b> Address <b>Wife Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic heart disease</b> <b>416 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>October 14, 1966</b> , to <b>Sept. 29, 1967</b> , that (I) <b>X</b> saw the deceased alive on <b>September 28, 1967</b> and that death occurred at <b>11:50 AM</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>September 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>William B. Gunther, M.D.</b>		22d. ADDRESS <b>4917 Edgewood Rd. College Park, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>29 10-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>SILVER SPRINGS MARYLAND</b>
24. FUNERAL DIRECTOR <b>GASCH'S</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 6 1967</b>	
25b. REGISTRAR'S SIGNATURE 			

72

SIGN.

1. *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12805

12814

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>P.G.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>44 days</i>		<i>East Riverdale</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>90 Magnolia Garden Nursing home</i>		d. STREET ADDRESS <i>6106 Madison St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Florence M. BUTLER</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>23</i> Year <i>1967</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>7-10-1881</i>	
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D C</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Degges</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>579 16 1601</i>	
17. INFORMANT <i>Florence M Dennis</i>		Address <i>East Riverdale, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i> <i>4221</i> DUE TO <i>Arteriosclerotic Cardio-vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>(1) Cerebral arteriosclerotic disease (2) Recent thrombophlebitis Lt leg</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8-10-1967</i> , to <i>9-23, 1967</i> , that (I) (we) last saw the deceased alive on <i>9-23 1967</i> , and that death occurred at <i>7:40 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>R. U. Franchi</i>		22b. DATE SIGNED <i>9-23-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. U. FRANCHI MD</i>		22d. ADDRESS <i>7729 Finnis Lane Lanham, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 26, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington Virginia</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>SEP 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12806

12815

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16-1 883***7402**Farmcrest***Carrollton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>7402 Farmcrest Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>CALLAWAY</b> Last <b>CALLAWAY</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAUCAS -</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 29, 1930</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>37</b> Days <b>3</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TIRE WHOLESALE SALES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TIRE CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Callaway</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Underwood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Constance Callaway Carrollton, Ind.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>pulmonary edema and shock</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>acute myocardial infarct with failure</b> DUE TO <b>4-6 hr</b> (c) <b>coronary artery atherosclerosis</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 1967, to <b>Sept</b> , 1967, that (I) (we) last saw the deceased alive on <b>3 Sept</b> , 1967, and that death occurred at <b>6:30</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>James W. Harding</b>		22b. DATE SIGNED <b>3 Sept 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES W. HARDING</b>		22d. ADDRESS <b>7601 Riverdale Rd. Lanham, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 7, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>SEP 8 1967</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>James W. Harding</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>75-3</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>Philadelphia</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Home 5805 Queens Chapel</b>				e. STREET ADDRESS <b>800 N. 63rd Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Theresa Campbell</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>1967</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/7/1877</b>		9. AGE (In years last birthday) <b>90</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Campbell</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Gertrude Delaney</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>202-05-5520</b>		17. INFORMANT Address <b>Sacred Heart Home, Hyattsville, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>55 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>53</b> , to <b>9/21</b> , 19 <b>67</b> , that (I) <del>did not</del> last saw the deceased alive on <b>9/21</b> , 19 <b>67</b> , and that death occurred at <b>2:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Thomas F Collins</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/22/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas F Collins, M.D.</b>				22d. ADDRESS <b>322 H St. N.E. Washington, D.C. 20002</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR <b>Francis J. Collins</b>				ADDRESS <b>3821 14th St. N.W. Washington, D. C.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

9. Total supply:

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3. *Conclusion*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12808						12817					
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Manor Nursing Home</b> <b>1922 LaSalle Rd.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1921 Kalorama Road N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Bertha</b>		First <b>G.</b> Middle <b>Carroll</b>		Last <b>Carroll</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>6</b> Year <b>1967</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/6/78</b>		9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper-Government</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James M. Carroll</b>						14. MOTHER'S MAIDEN NAME <b>Margaret M. Leahy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>577-38-1424</b>		17. INFORMANT <b>Sister Elizabeth Carroll</b> Address <b>Carroll Manor Nursing Home</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>472X</b> DUE TO (b) <b>Coronary Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs.</b> <b>10 Yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>19 Sept. 5</b> to <b>Sept. 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept. 5</b> , 19 <b>67</b> , and that death occurred at <b>6:15</b> M., from the causes and on the date stated above.											
22a. SIGNATURE <b>Harold Heiges</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/6/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>Harold Heiges MD</b>				22d. ADDRESS <b>5415 Conn. Ave NW DC</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges Co. Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b> ADDRESS <b>2901 14th St. N. W.</b>						25a. REC'D BY REGISTRAR <b>SEP 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12803

CERTIFICATE OF DEATH

12818

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>P.G.</b> <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>5409 Addison Road, NE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bessie Charles</b>		4. DATE OF DEATH Month Day Year <b>Sept. 29. 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/10</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>S. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John T. Watts</b>		14. MOTHER'S MAIDEN NAME <b>Petbell Tillman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Evelyn Newsome</b>		Address <b>5409 Addison Rd. Chapel Oaks, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Embolii</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>Sept. 24, 19 67</b> , to <b>Sept. 29, 19 67</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>Sept. 29, 19 67</b> , and that death occurred at <b>5:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. Clark Holmes</b>		22b. DATE SIGNED <b>9/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>10-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Hickland Park Md.</b>
24. FUNERAL DIRECTOR <b>H.S. Wookingfer 4 Smd 4425 Deane Ave NE</b>		25. REC'D BY REGISTRAR <b>OCT 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



STATE OF ALABAMA  
COUNTY OF ...

1947

TESTAMENT OF DEATH

State of Alabama

Prince Georges

Washington

North

2009 Addition Road, NE

Prince Georges General Hospital

Page 10

Charles

Harris

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State

Female

Prince Georges General Hospital

Prince Georges General Hospital

Prince Georges General Hospital

Page 10

1947

10

Prince Georges General Hospital

A. Clark Holmes, Jr.

10-1-47

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12810

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12819

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>Glenn Dale, Road</b>		
3. NAME OF DECEASED (Type or print) First <b>Carmela</b> Middle <b>M.</b> Last <b>Cipriano</b>			4. DATE OF DEATH Month <b>9</b> Day <b>20</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 June 1895</b>		9. AGE (In years lost birthday) <b>72</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>James Russo</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215 548 435</b>		17. INFORMANT <b>Joseph Cipriano</b> Address <b>Greenbelt, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		22. DATE SIGNED <b>9-21-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 25 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4 1  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12811

12820

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE Co.</u> <u>md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>B.</u> Middle <u>CLARK</u> Last				4. DATE OF DEATH <u>Sept. 27</u> 19 <u>67</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-91</u>	
				9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US GOVT.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William F. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Ida V. Sheets</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII 1917-1919</u>				16. SOCIAL SECURITY NO. <u>Wm 1917-1919</u>		17. INFORMANT <u>Grace Clark</u> Address <u>WASH. DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Interval between onset and death <u>10 YRS</u> <u>20 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 11</u> , 19 <u>62</u> , to <u>Sept. 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept. 27</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>W.B. Sheer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Sept. 28, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>				22d. ADDRESS <u>6400 MARLBORO PIKE S.E. WASH. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD</u>	
24. FUNERAL DIRECTOR <u>J. Wm. Lee + Son</u> ADDRESS <u>464 + mass ave WASH. DC</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1922

DEPARTMENT OF AGRICULTURE



Geo. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12812 CERTIFICATE OF DEATH 12821

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE (Bel Air)</u>				c. LENGTH OF STAY IN 1b <u>2 WKS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Starlight Lane</u>				e. STREET ADDRESS <u>508 TRUITT ST.</u>			
3. NAME OF DECEASED (Type or print) <u>NANNIE MAE (SMITH-LEMON) COLONATO</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 28 1906</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SOMERSET CO., MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDER H. GREEN</u>				14. MOTHER'S MAIDEN NAME <u>DAISY POPE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-10-8737</u>			
17. INFORMANT <u>ALLAN SMITH (SON)</u>				Address <u>12319 STARLIGHT BOULIE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH <u>2 MINUTES</u>			
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>SEPT 10, 1967</u> to <u>SEPT 10, 1967</u> , that (I) ( <del>the</del> ) last saw the deceased alive on <u>SEPT 10, 1967</u> , and that death occurred at <u>3:41</u> A.M. from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <u>Clyde L. Bell Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>Clyde L. Bell Jr. M.D.</u>				22b. DATE SIGNED <u>SEPT 10, 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept. 12, 1967</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 14 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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07/11/1901

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1901

ALEXANDER II

Sept. 15, 1903 (London Cemetery)

WILLIAM & COMPANY, SLEIGHBURY, WYLAND

SEP 14 1901

SLEIGHBURY, WYLAND



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12813

12822

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>12718 Kincaid Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Anthony</b> Last <b>Costa</b>				4. DATE OF DEATH Month <b>9</b> Day <b>20</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-1925</b>		9. AGE (In years lost birthday) yrs. <b>42</b>	10. IF UNDER 1 YEAR Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Educational Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing Company</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
13. FATHER'S NAME <b>John Costa</b>				14. MOTHER'S MAIDEN NAME <b>Marion Martin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>032-18-1205</b>		17. INFORMANT Address <b>Mrs. Dorothy Costa - Same as Item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO <b>Coronary artery occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>From coronary atherosclerotic heart disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22. DATE SIGNED <b>9-21-67</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Durham North Carolina</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Fun'l Home - Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 22 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1952

James Earl Ray

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U. S. A.

Publication Massachusetts  
Company

Publication Salem

James Earl Ray

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025-18-1-02 Mrs. Dorothy Costa-  
James Earl Ray

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James Earl Ray

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12823

12814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> P.G. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>DO<sup>A</sup></b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Englewood</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>1615 60th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Washington Crawford</b>				4. DATE OF DEATH Month Day Year <b>9 23 19 67</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>20 Aug., 1879</b>	
9. AGE (In years last birthday) yrs. <b>88</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Crawford</b>			
14. MOTHER'S MAIDEN NAME <b>Louise Bowser</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Elizabeth Wilson-granddaughter</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Min.</b>  <b>over 5 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe, M.D., Riverdale</b>				22. DATE SIGNED <b>924-67</b>			
EXAMINER'S NAME (Type)				23a. BURIAL, CREMATION, REMOVAL (Specify)			
23b. DATE THEREOF <b>9/27/67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ascension Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Bowie, Maryland</b>	
24. FUNERAL DIRECTOR <b>Stewart Funeral Home-4001 Benning Road</b>				25a. REC'D BY REGISTRAR DATE <b>N. SEP 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Mr. J. B. ...

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

12815

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12824

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN TB <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>3115 Twig Lane</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William K Cummins</b>		4. DATE OF DEATH Month Day Year <b>9 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Oct. 1915</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Ret) Lt Col</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>	
11. BIRTHPLACE (State or foreign country) <b>Manila Philippines</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, state branch and dates of service) <b>YES White/Green</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>KATHLEEN V. Cummins</b>		Address <b>#2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>443X</b> DUE TO <b>Hypertensive cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		22. DATE SIGNED <b>9-20-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>Sept 21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FLINCOLN CREMATORY</b>	23d. LOCATION (City or Town) (County) (State) <b>Blacksburg Prince Georges and</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>SEP 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>550 WASH BLVD NW</b>	

2002

UNITED STATES DEPARTMENT OF JUSTICE

Attorney General

Department of Justice

Washington, D.C.

Office

Room

Telephone

Facsimile

Teletype

Mail

Director

Chief

Assistant

Special Agent

Inspector

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12816

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12825

1. PLACE OF DEATH o. CDUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>D.C.</b> b. CDUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>41 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>264 16th Street, S.E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Davis, Jr.</b> Last <b>Davis, Jr.</b>		4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-39</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.	IF UNDER 24 HRS. Hours <b>27</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Holley Hill, South Caro.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Davis, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Fuller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>247-68-3806</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe gastrointestinal hemorrhage</b> DUE TO (b) <b>Ulcer of the stomach</b> DUE TO (c) <b>Pulmonary and central nervous system sarcoidosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>unknown</b> <b>23 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemoglobin S-C disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>8/27</b> , 19 <b>67</b> , to <b>9/12/</b> , 19 <b>67</b> , that (a) (we) last saw the deceased alive on <b>9/12/</b> , 19 <b>67</b> , and that death occurred at <b>3:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>9-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9.17.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Vances, S.C.</b>
24. FUNERAL DIRECTOR <b>Rollins Funeral Home</b>		25a. REC'D BY REGISTRAR <b>WASH, D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>SEP 18 1967</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

7-280158

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12817

CERTIFICATE OF DEATH

12826

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>Rt. 4, Box 100</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Dawson</b>			4. DATE OF DEATH Month <b>September</b> Day <b>16</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1967</b>	9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George's, Maryland</b>	
13. FATHER'S NAME <b>Paul Dawson</b>			14. MOTHER'S MAIDEN NAME <b>Connie Hamilton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Mother</b> Address <b>As above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemolytic disease of the newborn</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Prematurity</b> DUE TO (c) <b>Respiratory insufficiency</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 16, 1967</b> , to <b>Sept. 16, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Sept. 16, 1967</b> , and that death occurred at <b>5:25 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Iradi Mahdavi</i>			22b. DATE SIGNED <b>Sept. 16, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Iradi Mahdavi, M.D.</b>			22d. ADDRESS <b>6821 Riverdale Road, Riverdale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>9/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly PG Md.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Penn, Jr., Admin., Cheverly, Maryland</b>			25a. REC'D BY REGISTRAR <b>SEP 26 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

Division of Adult Education, U.S. Department of the Interior, Bureau of Indian Affairs, 1911-1912, 1913-1914, 1915-1916, 1917-1918, 1919-1920, 1921-1922, 1923-1924, 1925-1926, 1927-1928, 1929-1930, 1931-1932, 1933-1934, 1935-1936, 1937-1938, 1939-1940, 1941-1942, 1943-1944, 1945-1946, 1947-1948, 1949-1950, 1951-1952, 1953-1954, 1955-1956, 1957-1958, 1959-1960, 1961-1962, 1963-1964, 1965-1966, 1967-1968, 1969-1970, 1971-1972, 1973-1974, 1975-1976, 1977-1978, 1979-1980, 1981-1982, 1983-1984, 1985-1986, 1987-1988, 1989-1990, 1991-1992, 1993-1994, 1995-1996, 1997-1998, 1999-2000, 2001-2002, 2003-2004, 2005-2006, 2007-2008, 2009-2010, 2011-2012, 2013-2014, 2015-2016, 2017-2018, 2019-2020, 2021-2022, 2023-2024, 2025-2026, 2027-2028, 2029-2030, 2031-2032, 2033-2034, 2035-2036, 2037-2038, 2039-2040, 2041-2042, 2043-2044, 2045-2046, 2047-2048, 2049-2050, 2051-2052, 2053-2054, 2055-2056, 2057-2058, 2059-2060, 2061-2062, 2063-2064, 2065-2066, 2067-2068, 2069-2070, 2071-2072, 2073-2074, 2075-2076, 2077-2078, 2079-2080, 2081-2082, 2083-2084, 2085-2086, 2087-2088, 2089-2090, 2091-2092, 2093-2094, 2095-2096, 2097-2098, 2099-2100, 2101-2102, 2103-2104, 2105-2106, 2107-2108, 2109-2110, 2111-2112, 2113-2114, 2115-2116, 2117-2118, 2119-2120, 2121-2122, 2123-2124, 2125-2126, 2127-2128, 2129-2130, 2131-2132, 2133-2134, 2135-2136, 2137-2138, 2139-2140, 2141-2142, 2143-2144, 2145-2146, 2147-2148, 2149-2150, 2151-2152, 2153-2154, 2155-2156, 2157-2158, 2159-2160, 2161-2162, 2163-2164, 2165-2166, 2167-2168, 2169-2170, 2171-2172, 2173-2174, 2175-2176, 2177-2178, 2179-2180, 2181-2182, 2183-2184, 2185-2186, 2187-2188, 2189-2190, 2191-2192, 2193-2194, 2195-2196, 2197-2198, 2199-2200, 2201-2202, 2203-2204, 2205-2206, 2207-2208, 2209-2210, 2211-2212, 2213-2214, 2215-2216, 2217-2218, 2219-2220, 2221-2222, 2223-2224, 2225-2226, 2227-2228, 2229-2230, 2231-2232, 2233-2234, 2235-2236, 2237-2238, 2239-2240, 2241-2242, 2243-2244, 2245-2246, 2247-2248, 2249-2250, 2251-2252, 2253-2254, 2255-2256, 2257-2258, 2259-2260, 2261-2262, 2263-2264, 2265-2266, 2267-2268, 2269-2270, 2271-2272, 2273-2274, 2275-2276, 2277-2278, 2279-2280, 2281-2282, 2283-2284, 2285-2286, 2287-2288, 2289-2290, 2291-2292, 2293-2294, 2295-2296, 2297-2298, 2299-2300, 2301-2302, 2303-2304, 2305-2306, 2307-2308, 2309-2310, 2311-2312, 2313-2314, 2315-2316, 2317-2318, 2319-2320, 2321-2322, 2323-2324, 2325-2326, 2327-2328, 2329-2330, 2331-2332, 2333-2334, 2335-2336, 2337-2338, 2339-2340, 2341-2342, 2343-2344, 2345-2346, 2347-2348, 2349-2350, 2351-2352, 2353-2354, 2355-2356, 2357-2358, 2359-2360, 2361-2362, 2363-2364, 2365-2366, 2367-2368, 2369-2370, 2371-2372, 2373-2374, 2375-2376, 2377-2378, 2379-2380, 2381-2382, 2383-2384, 2385-2386, 2387-2388, 2389-2390, 2391-2392, 2393-2394, 2395-2396, 2397-2398, 2399-2400, 2401-2402, 2403-2404, 2405-2406, 2407-2408, 2409-2410, 2411-2412, 2413-2414, 2415-2416, 2417-2418, 2419-2420, 2421-2422, 2423-2424, 2425-2426, 2427-2428, 2429-2430, 2431-2432, 2433-2434, 2435-2436, 2437-2438, 2439-2440, 2441-2442, 2443-2444, 2445-2446, 2447-2448, 2449-2450, 2451-2452, 2453-2454, 2455-2456, 2457-2458, 2459-2460, 2461-2462, 2463-2464, 2465-2466, 2467-2468, 2469-2470, 2471-2472, 2473-2474, 2475-2476, 2477-2478, 2479-2480, 2481-2482, 2483-2484, 2485-2486, 2487-2488, 2489-2490, 2491-2492, 2493-2494, 2495-2496, 2497-2498, 2499-2500, 2501-2502, 2503-2504, 2505-2506, 2507-2508, 2509-2510, 2511-2512, 2513-2514, 2515-2516, 2517-2518, 2519-2520, 2521-2522, 2523-2524, 2525-2526, 2527-2528, 2529-2530, 2531-2532, 2533-2534, 2535-2536, 2537-2538, 2539-2540, 2541-2542, 2543-2544, 2545-2546, 2547-2548, 2549-2550, 2551-2552, 2553-2554, 2555-2556, 2557-2558, 2559-2560, 2561-2562, 2563-2564, 2565-2566, 2567-2568, 2569-2570, 2571-2572, 2573-2574, 2575-2576, 2577-2578, 2579-2580, 2581-2582, 2583-2584, 2585-2586, 2587-2588, 2589-2590, 2591-2592, 2593-2594, 2595-2596, 2597-2598, 2599-2600, 2601-2602, 2603-2604, 2605-2606, 2607-2608, 2609-2610, 2611-2612, 2613-2614, 2615-2616, 2617-2618, 2619-2620, 2621-2622, 2623-2624, 2625-2626, 2627-2628, 2629-2630, 2631-2632, 2633-2634, 2635-2636, 2637-2638, 2639-2640, 2641-2642, 2643-2644, 2645-2646,

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10 21 1940

0821 Riverdale Road, Riverdale, Md.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12827

12813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hr. 15 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>&amp; Prince George Gen. Hosp.</b>			d. STREET ADDRESS <b>103 73rd. St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Dennis</b> Last <b>Dennis</b>			4. DATE OF DEATH Month <b>9</b> Day <b>20</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 April 1913</b>		9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
13. FATHER'S NAME <b>? Dennis</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret I. Dennis, General Delivery</b> Address <b>Knoxville, Tennessee</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>443X</b> DUE TO <b>Hypertensive cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe, M.D.</b>			22. DATE SIGNED <b>9-20-67</b>		
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Forest Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Concord, Tennessee</b>		
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>			25a. REC'D BY REGISTRAR DATE <b>SEP 25 1967</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

6308 Antioch Road, Antioch, Maryland  
Robert L. Williams General Home

William Forest Cemetery Concord, Tennessee

X

X

and the number of persons

and the number of persons

General Delivery  
Knoxville, Tennessee

Unknown

Donna

Tennessee

Construction

Stone Mason

1913

Raymond

1913

1913

1913

1913

1913

1913

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

12819

12828

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>OHIO</b> b. COUNTY <b>Columbiana</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AF BASE</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALEM</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>829 AETNA ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>HOMER DETWILER</b>				<b>4. DATE OF DEATH</b> Month <b>SEPT</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 FEB 1915</b>		9. AGE (In years lost birthday) yrs. <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WILLIAMS MFCT CO</b>		11. BIRTHPLACE (County & State, or foreign country) <b>SALEM OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN DETWILER</b>				14. MOTHER'S MAIDEN NAME <b>MARY LOTTMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>216-337-3748</b>		17. INFORMANT <b>WIFE SAME AS #2</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GLIOBLASTOMA MULTIFORME, INFILTRATING</b> 1939 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <b>19 Sep</b> , 19 <b>67</b> , to <b>20 Sep</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>20 Sep</b> , 19 <b>67</b> , and that death occurred at <b>4:20</b> AM from causes and on the date stated above.							
22a. SIGNATURE <i>Gaetano F. Molinari</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>20 Sep 67</b>			
22c. PHYSICIAN'S NAME (Type) <b>GAETANO F. MOLINARI, CAPT, USAF, MC</b>			22d. ADDRESS <b>USAF Hospital Andrews Andrews AFB Wash DC 20331</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>9-21-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GRANDVIEW CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>Akron, Ohio</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash. DC.</b>			ADDRESS 25a. REC'D BY REGISTRAR <b>SEP 27 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		

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ANDREW H. BART

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12820

12830

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clinton Community Hospital</b>		d. STREET ADDRESS <b>Clinton, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Oliver A. Doyle</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1885</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.N.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>CHRISTOPHER AUTHENRIETH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>JAMES A DOYLE</b>		Address <b>1427 JOHN ST BAITO, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive-arteriosclerotic HD</b> DUE TO (c) <b>Very advanced age of 83</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNK.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Profound anemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Merkle</b>		22b. DATE SIGNED <b>9/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT W MERKLE</b>		22d. ADDRESS <b>CLINTON MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/13/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>		23d. LOCATION (City or town) (County) (State) <b>FORT MYER VA.</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO., INC. WASHINGTON, D.C.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>gcharles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12821

CERTIFICATE OF DEATH

12831

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>			c. LENGTH OF STAY IN 1b <b>9 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> 16.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pineview Gardens</b>				d. STREET ADDRESS <b>Dyson Rd. Rta Box 301A</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Henry Duckett</b>				4. DATE OF DEATH Month Day Year <b>9 20 19 67</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/17/17</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Charles co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Zebra Duckett</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Robinson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>James C. Duckett Hunting Town, Md. Box 376</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> DUE TO (b) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (c) <b>ARTERIOSCLEROSIS &amp; HYPERTENSION.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC URINARY TRACT INFECTION. POSSIBLE SEPTIS.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if (this hospital) attended the deceased from <b>1-25</b> , 19 <b>67</b> , to <b>9-20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-20</b> 19 <b>67</b> , and that death occurred on <b>12-30</b> A.M. from causes and on the date stated above.							
22a. SIGNATURE <b>RALPH LEW, M.D.</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>RALPH LEW, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>9-23-67</b>		<b>Apostolic Ch. Cemetery</b>		<b>Brandywine P. Ch. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Marcell Adams Aquasco, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 57  
6M 1/67

12822

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12832

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY in 1b <b>4 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hyattsville Nursing Home</b>				d. STREET ADDRESS <b>7520 Maple Ave., Apt. 304</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sara</b> Middle <b>A</b> Last <b>Dyer</b>				4. DATE OF DEATH Month <b>9</b> Day <b>2</b> Year <b>19 67</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 July 1888</b>	9. AGE (In years last birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry L. Dyer</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Clear</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-46-9229 A</b>		17. INFORMANT <b>Helen K. Dyer</b> Address <b>7520 Maple Avenue Takoma Park, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4 200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>9-3-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Sept. 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Port Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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*[Handwritten signature]*



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12833

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Kentland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kentland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 7239 79th Avenue		16.1	
3. NAME OF DECEASED (Type or print) James E. Eader		First Middle Last		4. DATE OF DEATH September 24 1967		Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1944	9. AGE (In years last birthday) 22 2/3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. Eader				14. MOTHER'S MAIDEN NAME Bertha Cosgrove			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-42-3289		17. INFORMANT Ruth Eader		Address Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive skull fracture 815.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractures, compound of left radius & ulna & left tibia & fibula DUE TO (c) Multiple fractures of facial bones							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) d) Motorcycle-Automobile Accident (Operator of Motorcycle)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Motorcycle-Automobile Accident (Operator of Motorcycle)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 6:40 9/24 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1300 block Brightseat Rd., Landover, P.G. MD.		20f. (City or town) (County) (State) Landover, P.G. MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 9/25/67 Address (Street, city, town, or county) Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/67		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.				25a. REC'D BY REGISTRAR DATE SEP 29 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12834

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b> d. STREET ADDRESS <b>7239 79th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert Edward Eader</b>			4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1967</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1964</b>		9. AGE (In years last birthday) <b>2 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James E. Eader</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Chesky</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Ruth Eader</b> Address <b>Item # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture of left hand &amp; left femur</b> <b>815.4</b> DUE TO (b) <b>Massive skull fracture, compound, depressed</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Motorcycle-automobile accident. (Passenger on Motorcycle)</b>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Motorcycle-automobile accident (Passenger on motorcycle)</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>6:40 p.m.</b> <b>9/24/ 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1300block Brightseat Rd., Landover, P.G. Md.</b>			
20f. (City or town) (County) (State) <b>Landover, P.G. Md.</b>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>9/25/67</b> Address (Street, city, town, or county) <b>Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>			
23d. LOCATION (City, town or county) (State) <b>Rockville, Md.</b>							
24. FUNERAL DIRECTOR <b>Yson Wheeler Funeral Home-1331 Rockville Pike</b> <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1100 George's Highway, Dept. 121

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(continued on next page)

745379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #11 infor. taken from birth cert.

12825

CERTIFICATE OF DEATH

14282

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>Few Seconds</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>2413 Vermont Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Girl Eschevarria</b>				4. DATE OF DEATH Month Day Year <b>Sept. 20, 1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 20, 1967</b>		9. AGE (In years lost birthday) yrs. <b>16-1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Cheverly, P.G.</b>		12. CITIZEN OF WHAT COUNTRY? <b>1/2</b>	
13. FATHER'S NAME <b>Libertad Eschevarria</b>				14. MOTHER'S MAIDEN NAME <b>Isauva Santiago</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7625</b> IMMEDIATE CAUSE (a) <b>1) Prematurity, Baby died few seconds after delivery. Aetiology of death unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <b>2) Atelectasis of lungs. bilateral.</b> DUE TO (c) <b>Few mts.</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>3:15 pm 9/20/1967</b> , to <b>3:25 pm 9/20/1967</b> , that <del>he</del> (we) lost saw the deceased alive on <b>a few mts after birth</b> and that death occurred at <b>3:10 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Farizar Kazema</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept. 20, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Farizar Kazema, M. D.</b>				22d. ADDRESS <b>Prince Georges General Hospital.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>10/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Md.</b>			
24. FUNERAL DIRECTOR <b>HARRY W. PENND, JR., ADMINISTRATOR</b>				25a. REC'D BY REGISTRAR <b>OCT 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

7-279931

11223

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Arrived

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

12826

12835

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 4 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>				d. STREET ADDRESS <u>404 Lincoln Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Edinger</u> Last <u></u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1880</u>	9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Edinger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gibb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>814 772 1426</u>		17. INFORMANT <u>Mr. George Minor</u>		Address <u>404 Lincoln Ave - Takoma Park</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebrovascular accident.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture, right femur.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in nursing home due to above.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7/25</u> 19 <u>67</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing home</u>		20f. (City or town) (County) (State) <u>Hyattsv. Prince Georges Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Sept 16</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 16</u> 19 <u>67</u> , and that death occurred at <u></u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William F. Simpson</u>				22b. DATE SIGNED <u>9/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson</u>	
22d. ADDRESS <u>6216 N.H. Ave NE</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Warren Prince Georges Md</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters, 234 Carroll St NW Wash DC</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Kehoe notified & will perform

12-22

RECEIVED

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12-22

TO THE HONORABLE CHIEF OF POLICE  
CITY OF NEW YORK  
FROM THE NEW YORK CITY POLICE DEPARTMENT  
RE: [illegible]

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12827

## CERTIFICATE OF DEATH

12836

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		c. LENGTH OF STAY IN 1b <b>16.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>409 Addison Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PATRICIA</b>		4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-3-1952</b>	
9. AGE (In years last birthday) <b>15</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard R. Edwards, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mildred J. McGuire</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Bernard R. Edwards</b>		Address <b>409 Addison Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1907</b> IMMEDIATE CAUSE (a) <b>Melanoma of Lg with</b> DUE TO <b>metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>9 months</b> (c) <b>9 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/27</b> , 19 <b>67</b> , to <b>9/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/8</b> , 19 <b>67</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above		22a. SIGNATURE <b>William Brainin</b> M.D.	
22b. DATE SIGNED <b>9/18/67</b>		22c. PHYSICIAN'S NAME (Type) <b>W M. BRAININ</b>	
22d. ADDRESS <b>6124 Central Ave, Capital City, Md</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-11-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Clinton Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road Suitland Maryland</b>		25. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12828

CERTIFICATE OF DEATH

12837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3-1/2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>3200 Rhode Island Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine F. Feddon</b>				4. DATE OF DEATH Month Day Year <b>Sept. 22, 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 6, 1899</b>	
9. AGE (In years lost birthday) yrs. <b>68</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Nalley's Funeral Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash., D.C.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Thomas R. Nalley</b>			
14. MOTHER'S MAIDEN NAME <b>Kathryn Murray</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>577-40-3881</b>				17. INFORMANT <b>Thomas F. Feddon - St., Alex., Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cause arrest -</b> <b>1420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary &amp; Renal</b> DUE TO (c) <b>Post-operative status - Parathyroidectomy</b>				INTERVAL BETWEEN ONSET AND DEATH <b>25 min</b> <b>16 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Which cell tumor of parathyroid gland (right)</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (physician) attended the deceased from <b>9-18</b> , 19 <b>67</b> , to <b>Sept. 22, 1967</b> , that (I) (see) last saw the deceased alive on <b>Sept. 22, 1967</b> , and that death occurred at <b>4:30 AM</b> from causes and on the date stated above.		22a. SIGNATURE <b>Richard D. Bauer, M.D.</b> 22b. DATE SIGNED <b>Sept. 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard D. Bauer, M.D.</b>		22d. ADDRESS <b>2513 Bucklodge Road, Adelphi, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Com.</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>		24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc., Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

CERTIFICATE OF DEATH

1987

Place of death: \_\_\_\_\_

Date of death: \_\_\_\_\_

Since death occurred: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

*[Faint, illegible handwritten text]*

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SEP 17 1987



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

74

2

VR A15 (4)  
25M 1/67

2

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12829

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #11,12,13 & 14 Film #G393 10/11/67 ph

CERTIFICATE OF DEATH

Fetty M  
12838

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4908 22nd Place</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret M. Fetty</b>		4. DATE OF DEATH Month Day Year <b>Sept. 24, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/06</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Swampscott, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lester M. Doane</b>		14. MOTHER'S MAIDEN NAME <b>Margaret McCarthy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X Pneumonia</b> DUE TO (b) <b>Broncho Esophageal Fistula</b> DUE TO (c) <b>Carcinoma of Esophagus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>64</b> , to <b>Sept 24</b> , 19 <b>67</b> , that (I) (xxx) last saw the deceased alive on <b>Sept 23</b> , 19 <b>67</b> , and that death occurred at <b>10</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>George William Ware</b>		22b. DATE SIGNED <b>Sept. 25, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>George William Ware, M. D.</b>		22d. ADDRESS <b>1835 Ege St NW</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>9-27-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GEORGETOWN MED. SCH</b>		23d. LOCATION (City or Town) (County) (State) <b>WASH. DC.</b>	
24. FUNERAL DIRECTOR <b>John F. De Vof</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1967</b>	
ADDRESS <b>Washington DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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1206-25-3022

George William Fane

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FOR STATE  
HEALTH DEPT.

12830  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12839

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Prince George's</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George's</b>                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Suitland</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Andrews Air Force Base Hospital</b>  |                                     | d. STREET ADDRESS<br><b>Rt. 1, Box 1339 Flowers Lane</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Regina Lee Fletcher</b>  |                                     | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>27</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8. DATE OF BIRTH<br><b>1-16-1963</b>  |
| 9. AGE (In years lost birthday)<br><b>4</b> yrs.  |                                     | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>27</b> Hours <b>19</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |   |
| 13. FATHER'S NAME<br><b>James E Fletcher</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>MARY ANNA PEREZ</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>MARY A. Fletcher</b>  |                                     | Address<br><b>Same as 2 D</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Crushing injury of chest and abdomen</b><br><b>830.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO<br>(c) _____  |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>min.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Crushed between Car and building.</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <b>10:30am</b> p.m. <b>9-27- 19 67</b>  |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Driveway of home</b>   |                                     | 20f. (City or town) (County) (State)<br><b>Same as #2</b>   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Motorol causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> |                                     |   |   |
| ACTUAL SIGNATURE<br><b>John Kehoe</b> M.D.  |                                     | 22. DATE SIGNED<br><b>9-28-67</b>   |   |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |                                     | Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>9-30-67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Calvary</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Forestville MD</b>                            |
| 24. FUNERAL DIRECTOR<br><b>H.S. Washington &amp; Sons 4925 Deane Ave NE</b>   |                                     | 25a. REC'D BY REGISTRAR<br><b>OCT 2 1967</b>  |   |
|   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

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*[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "The", "and", "of" are visible.]*

OCT 2 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2a,b,c & d File #G393 10/11/67 ph

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland/ Va.</b> b. COUNTY <b>Prince George's</b>     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lanham/ South Arlington</b>  |  |
| c. LENGTH OF STAY in 1b<br><b>2 days</b>  |                                  | d. STREET ADDRESS <b>1121 20th St. Home</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Martha</b> Middle <b>N.</b> Last <b>Ford</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>29,</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/17/83</b>   |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>19</b> Hours <b>67</b> Min.  | IF UNDER 24 HRS.<br>Hours <b>67</b> Min.                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  | 13. FATHER'S NAME<br><b>John Keese</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>579-48-7681</b>   |                                  | 17. INFORMANT<br><b>Nellie Jennings - Rt.#1, Box 325, Bowie, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4201</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia, basilar, bilateral (organism undetermined)</b><br>DUE TO (b) <b>Congestive Heart Failure</b><br>DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b> |                                  | INTERVAL BETWEEN DEATH AND REPORT<br><b>4 Remia</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyonephrosis, left side. Peptic Ulcer, cardia of esophagus.</b>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>Sept 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>9/29</b> 19 <b>67</b> , and that death occurred at <b>11:05 PM</b> , from causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Leon R. Levitsky, M.D.</b>   |                                  | 22b. DATE SIGNED<br><b>9/30/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Leon R. Levitsky, M.D.</b>   |                                  | 22d. ADDRESS<br><b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Oct. 3, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch &amp; Sons Hyattsville, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>OCT 6 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12832

CERTIFICATE OF DEATH

12841

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b> MARYLAND   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b>   |   | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Beltsville</b> 16-1 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Eugene Leland Memorial Hospital</b>   |   |   | d. STREET ADDRESS<br><b>4921 Pr. George's Ave.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Anna T Forner</b>   |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>September 16 19 67</b>  |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>01/29/07</b>  |  | 9. AGE (In years last birthday) yrs.<br><b>60</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Wash., DC</b>                                    |   |
| 13. FATHER'S NAME<br><b>Arthur Mulloy</b>  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Anne Shea</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>213 44 5001</b>   |  | 17. INFORMANT<br><b>Peter C Forner</b> Address<br><b>Beltsville, Md.</b>                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b><br>DUE TO (b) <b>with Metastases</b><br>DUE TO (c) <b>with Metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mo</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1967</b> to <b>Sept 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 15, 1967</b> , and that death occurred at <b>7:30</b> M, from causes and on the date stated above.   |   |   |  |  |   |
| 22a. SIGNATURE<br><b>L.W. Malin</b> M.D.   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>Sept 16, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L.W. MALIN, M.D.</b>  |   | 22d. ADDRESS<br><b>Riverdale, Md.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Sept 18, 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mercersburg Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Greencastle Franklin Pa</b>                            |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b> ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 19 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

James Beane

Harvey

Belleville

101 W. George Ave.

Anna

Robert

Marie

OW 23/07

Wash., DC

Anna Shes

Arthur Muiroy

Belleville, Mo.



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**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles W. Dr. John D. Dr. Acting Med. Co.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b>   |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Prince Georges</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  | c. LENGTH OF STAY IN lb<br><b>8 hrs. 45mins.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mitchellville</b>  |  | 1601  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>Box 48 Route 2</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First<br><b>Lowell</b>   |  | Middle<br><b>Frazee</b>   |  | Last<br><b>Sept. 24, 1967</b>   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. B. DATE OF BIRTH<br><b>10/19/82</b>  |  |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days   |  | 11. IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Accountant</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Treasury Dept.</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Bethel, Ohio</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Alfred Frazee</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollie Dunconson</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>217-36-6417</b>  |  | 17. INFORMANT<br><b>Daisy B. Frazee</b> Address<br><b>Route 2 Mitchellville, Maryland</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Mossai Mountain Thrombosis</b><br>4500 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Arterio-Sclerosis</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b> |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus</b>  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)<br><b>at P.M.</b>  |  |
| 21. I certify that (I) <del>(has been)</del> attended the deceased from <b>9-20</b> , 19 <b>67</b> , to <b>Sept. 24</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Sept. 24</b> , 19 <b>67</b> , and that death occurred at <b>9:45PM</b> , from causes on and on the date stated above  |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Saul Schwartzbach</b>  |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>Sept. 24, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Saul Schwartzbach, M. D.</b>   |  |  |  | 22d. ADDRESS<br><b>1726 Eye St., N.W. Washington, D.C.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Sept. 27, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>National Memorial Park</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Falls Church, Virginia</b>                    |  |
| 24. FUNERAL DIRECTOR<br><b>C. Glen Carter</b>   |  | ADDRESS<br><b>8434 Georgia Avenue</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Warner E. Pumphrey, Inc.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |
| DATE <b>SEP 29 1967</b>   |  |  |  |   |  |   |  |

SEP 23 1957  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

21-37-117  
FEDERAL BUREAU OF INVESTIGATION  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME  
6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12844

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2 hrs</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Berwyn Heights</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>  |                                  |   | d. STREET ADDRESS<br><b>6220 Seminole Place</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Arthur Benjamin Gatton</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>13</b> Year <b>19 67</b>   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>18 Jan. 1891</b>  | 9. AGE (In years last birthday)<br><b>76</b> yrs.   | 10. UNDER 1 YEAR<br>Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min. <b>67</b>                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mechanic</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>Joseph B. Gatton</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Delphine Canter</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><b>577-10-8424</b>   |  | 17. INFORMANT<br><b>Mrs Catherine Mousseau</b> Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture of aortic aneurysm</b><br><b>451X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |                                  | M.D.<br><b>John Kehoe, M.D. Riverdale, Md.</b>  |  | 22. DATE SIGNED<br><b>9-14-67</b>   |   |
| EXAMINER'S NAME (Type)   |                                  | Address (Street, city, town, or county)   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/16/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Lee Funeral Home</b>  |                                  | ADDRESS<br><b>Washington, D.C.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 18 1967</b>   |   |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



100-100000-100000

100-100000-100000

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12836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12845

FOR STATE HEALTH DEPT.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>b. STATE <b>Maryland</b> c. COUNTY <b>Prince George's</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>  |  | d. STREET ADDRESS <b>7512 Hawthorne St.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Eleanor</b> Middle <b>Mae</b> Last <b>Gerra</b>   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>26</b> Year <b>19 67</b>   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>5-25-1937</b>  |
| 9. AGE (In years lost birthday) <b>30</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>16</b> Days <b>1</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  |
| 13. FATHER'S NAME <b>Elmer G. Thompson sr</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Agnes Beavers</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO. <b>220 32 5786</b>   |  |
| 17. INFORMANT <b>Steve Gerra</b>  |  | Address <b>Landover, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Undetermined</b><br><b>7955</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b><br>(c) <b>DUE TO</b>  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.   |  | 22. DATE SIGNED <b>9-27-67</b>   |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>Sept 30, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo. Md.</b>                 |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12837

12846

|  |                              |   |                                    |
|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGES</b><br>MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>b. COUNTY<br><b>Washington, D.C.</b>                   |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (rural)</b>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>   |                                    |
| c. LENGTH OF STAY IN 1b<br><b>3 months</b>   |                              | d. STREET ADDRESS<br><b>1307 P St., N.W.</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Glenn Dale Hospital</b>   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Marie Grady</b>  |                              | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 13, 19 67</b>  |                                    |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/9/06</b> |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.  |                              | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b>   |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Va.</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>Lucius Steel</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary Cone</b>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |                                    |
| 17. INFORMANT<br><b>decedent</b>   |                              | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver</b><br>5811<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c) DUE TO                               |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic alcoholism; arteriosclerotic heart disease with congestive heart failure; carcinoma of urinary bladder</b>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6/23/, 19 67</b> , to <b>9/13/67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/13/ 1967</b> , and that death occurred on <b>6:30P M</b> , from causes and on the date stated above. |                              |   |                                    |
| 22a. SIGNATURE<br><b>Moe Weiss</b>   |                              | 22b. DATE SIGNED<br><b>9/13/67</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Moe Weiss, M.D.</b>   |                              | 22d. ADDRESS<br><b>Glenn Dale Hospital, Glenn Dale, Md.</b>   |                                    |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                              | 23b. DATE THEREOF<br><b>Sept. 18, 1967</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>HARMONY MEMP. PK. CEMT. MD.</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Ind.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>UNIVERSAL FUNERAL Home</b>  |                              | 25a. REC'D BY REGISTRAR<br><b>SEP 19 1967</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                              |   |                                    |

THE CHAIRMAN'S REPORT ON THE PROGRESS OF THE WORK OF THE COMMISSION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner notified and released

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12838

12847

|  |                              |   |   |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH<br>P. COUNTY <b>P.G.</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>P. STATE <b>MARYLAND</b> b. COUNTY <b>P.G.</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RIVERDALE</b>   |                              | c. LENGTH OF STAY IN IB<br><b>4 1/2 hours</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>LELAND MEMORIAL HOSPITAL</b>  |                              | d. STREET ADDRESS<br><b>3605 TAYLOR STREET</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JOHN</b> First <b>C.</b> Middle <b>GRAY</b> Last <b>Sr</b>   |                              | 4. DATE OF DEATH<br><b>9-22</b> Month <b>19</b> Year <b>67</b>  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 16, 1892</b> |
| 9. AGE (In years birthday) <b>74</b> yrs.  |                              | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Transit Co</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Scotland</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>John Gray</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Christine Galloway</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>WW 1</b>  |   |
| 17. INFORMANT<br><b>Hospital records</b>   |                              | Address<br><b>Riverdale, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4201</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS</b> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-21</b> , 19 <b>67</b> , to <b>9-22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-21</b> , 19 <b>67</b> , and that death occurred at <b>1:40</b> AM, from causes and on the date stated above.  |                              |   |   |
| 22a. SIGNATURE<br><b>C. J. Houmann</b>   |                              | 22b. DATE SIGNED<br><b>9-22-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. J. HOUMANN</b>   |                              | 22d. ADDRESS<br><b>RIVERDALE MD</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>Sept 25, 1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |                              | 25a. REG. BY REGISTRAR<br><b>SEP 25 1967</b>  |   |
| ADDRESS<br><b>Hyattsville, Md.</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |

P.O.

CHARTER

P.O.

COOPER

12 MONTHS

REVENUE

2000 DOLLARS

1000 DOLLARS

2-20

100

100

10

100

10

U.S.A.

Scotland

100

100

Hospital record

5/10/10

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

12833

12848

|   |  |                                       |  |   |  |   |  |
|---|--|---------------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND  |  |                                       |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Forestville</b>  |  |                                       |  | c. LENGTH OF STAY IN TB   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Regent Nursing and Rehabilitation Center</b>   |  |                                       |  | d. STREET ADDRESS<br><b>5627 Regency Park Court</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>JOHN</b> First <b>GRECO</b> Middle <b>Greco</b> Last   |  |                                       |  | 4. DATE OF DEATH<br>Month <b>Sept</b> Day <b>24</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 28, 1915</b>                                     |  |
|   |  |                                       |  | 9. AGE (In years lost birthday)<br><b>52</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Electrician</b>   |  |                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Italy</b>           |  |
| 13. FATHER'S NAME<br><b>Frank Greco</b>   |  |                                       |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary DePasquale</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  |                                       |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Lorraine E. Greco</b> Address <b>5627 Regency Park Ct</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>163X</b> IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage Anemia</u><br>DUE TO <u>CA of Lung c metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____ |  |                                       |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b><br><b>10/66</b>                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)   |  |                                       |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                       |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
|   |  |                                       |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> , 19 <u>67</u> , to <u>9/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/21</u> , 19 <u>67</u> , and that death occurred at <u>1:15 PM</u> , from causes and on the date stated above.   |  |                                       |  |   |  |   |  |
| 22a. SIGNATURE<br><i>Frank J. Fedor</i>   |  |                                       |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>9/21/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>FRANK J. FEDOR MD</b>  |  |                                       |  | 22d. ADDRESS<br><b>4201 CATHEDRAL AVE N.W. D.C.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>9-25-1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Bladensburg Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm</b> ADDRESS <b>4398 Suitland Rd</b>  |  |                                       |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CERTIFICATE OF DEATH

State of Michigan

County of

City of

Residence

Birthplace

Age at death

Sex

Color

Date of death

Place of death

Cause of death

Signature of

Physician

Signature of

Coroner

Signature of

Notary Public

Commission Expires

Signature of

Registrar

Health Officer



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12840

12849

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGE COUNTY MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>WASHINGTON, D.C.</b><br>b. COUNTY                   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CLINTON MARYLAND</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>35 DAYS</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>PINE VIEW GARDENS HEALTH CARE CENTER CLINTON, MD.</b>  |  |   |  | e. STREET ADDRESS<br><b>2820 31st Street S.E.</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDITH</b> Middle <b>MAE</b> Last <b>GREENE</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>6</b> Year <b>1967</b>  |  |  |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-14-01</b>   |  |
| 9. AGE (In years last birthday)<br><b>66</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>NEW YORK, N.Y.</b>               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>FREDERICK JOHNSON</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>KATHERINE O'HEAL</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>GEORGE B. GREENE</b> Address <b>HILL CREST Hgts Md 3356 CURTIS DR.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Resp. &amp; CARDIAC ARREST (PROBABLE)</b><br>174X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>advanced Ca uterus</b><br>DUE TO<br>(c) |  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> , 19 <b>67</b> , to <b>9/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> , 19 <b>67</b> , and that death occurred at <b>5:30 A.M.</b> , from causes and on the date stated above.  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>E. Kaany</b>   |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>9-6-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E. KAANY, M.D.</b>   |  |   |  | 22d. ADDRESS<br><b>GREENBELT, MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>9-8-1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington Virginia</b>                 |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm</b><br><b>4308 Suitland Rd Suitland Maryland</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 11 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Jones</b>                                      |  |

STATE OF NEW YORK  
IN SENATE  
January 10, 1907  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1906  
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1907

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS  
1907

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Removal for the Hall Funeral Home, Purcellville, Va.

MEDICAL CERTIFICATION

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cottage city</b>  |   | c. LENGTH OF STAY IN 1b<br><b>Hrs.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Wooded area behind 4102 Parkwood St.</b>  |   | d. STREET ADDRESS<br><b>1408 18th pl., S.E.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Conley Worth Greer</b>  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>2</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>5 Jan., 1928</b>                                |
| 9. AGE (In years lost birthday) yrs. <b>39</b>   |   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Const. Co.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>Wiley t. Greer</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Etta McMillan</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WW II</b>   |   | 16. SOCIAL SECURITY NO.<br><b>?</b>  |  |
| 17. INFORMANT<br><b>Etta M. Greer</b>  |   | Address<br><b>Purcellville, Va. (Mother)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b><br>976 X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot self with .22 cal. revolver</b>                                |  |
| 20c. TIME OF INJURY<br>Hour <b>AM</b> Month <b>9</b> Day <b>2</b> Year <b>1967</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Same as #1</b>  |  |
| 20f. (City or town) (County) (State)   |   |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe, M.D., Riverdale</b>   |   | 22. DATE SIGNED<br><b>9-3-67</b>   |  |
| EXAMINER'S NAME (Type)   |   | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>9/5/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillsboro Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hillsboro, Va.</b> |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Hyattsville, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 8 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Francis Gasch</i>   |   |  |  |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12841

12850

47-3

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• 00 • 0000

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NAME: \_\_\_\_\_

(1950) 24, 211-11502A

7-58

23

15. *Journal of the American Medical Association*, 1997; 278: 1019-1024.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12842

CERTIFICATE OF DEATH

12851

|   |                                    |   |  |  |  |  |  |
|---|------------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGES</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANDREWS AF BASE</b><br>c. LENGTH OF STAY IN 1b<br><b>1 Hr</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>USAF HOSPITAL ANDREWS</b>   |                                    |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>DISTRICT OF COLUMBIA</b><br>b. COUNTY<br><b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON</b><br>d. STREET ADDRESS<br><b>133 IVANHOE ST SW APT 1A</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>D'JUARN DONTE' GUNN</b>   |                                    |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>SEPT 5 19 67</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGROID</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>23 Aug 1967</b>                                 | 9. AGE (In years last birthday)<br>— yrs.  | IF UNDER 1 YEAR<br>Months Days<br><b>14</b>                          | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NA</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NA</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>PRINCE GEORGES MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |
| 13. FATHER'S NAME<br><b>GILBERT GUNN</b>  |                                    |   |  | 14. MOTHER'S MAIDEN NAME<br><b>EARLINE P. WATSON</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                    | 16. SOCIAL SECURITY NO.<br><b>NA</b>  |  | 17. INFORMANT<br>Address<br><b>Mother SAME AS #2</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4330</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DEHYDRATION AND SEPSIS</b> |                                    |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Hr</b>                        |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)                                 |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2 Sept</b> , 19 <b>67</b> , to <b>5 Sept</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>5 Sept</b> , 19 <b>67</b> , and that death occurred at <b>5:10 PM</b> from causes and on the date stated above.  |                                    |   |  |  |  |  |  |
| 22a. SIGNATURE<br><i>Herrick J. Cohen</i>   |                                    |   |  | 22b. DATE SIGNED<br><b>5 Sept 1967</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>HERRICK J. COHEN, CAPT, USAF MC</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                    | 23b. DATE THEREOF<br><b>9-11-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Nat.</b>            |  | 23d. LOCATION (City or town) (County) (State)<br><b>Arlington Va</b> |  |  |
| 24. FUNERAL DIRECTOR<br><i>Prozin 389 R.I. are m. Wash DC</i>   |                                    |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 11 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                     |  |

1-271200

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

TO: DIRECTOR, FBI (100-374302)

SUBJECT: JAMES EARL RAY; AKA; ALIASES; FUGITIVE

RE: NEW YORK TELETYPE TO BUREAU, 1/10/68

1. On 1/10/68, the New York Office received information

from the New York State Police that James Earl Ray

had been seen in the New York City area on 1/10/68.

2. The New York Office is currently conducting an

extensive search of the New York City area for Ray.

3. The New York Office is currently conducting an

extensive search of the New York City area for Ray.

4. The New York Office is currently conducting an

extensive search of the New York City area for Ray.

5. The New York Office is currently conducting an

extensive search of the New York City area for Ray.

6. The New York Office is currently conducting an

extensive search of the New York City area for Ray.

7. The New York Office is currently conducting an

extensive search of the New York City area for Ray.

8. The New York Office is currently conducting an

extensive search of the New York City area for Ray.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

7-279921

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12843

CERTIFICATE OF DEATH

12852

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George</b>      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |   | c. LENGTH OF STAY IN 1b<br><b>30 hours</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>  |   | d. STREET ADDRESS<br><b>8110 Sherriff Road</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Baby Girl Hall</b>  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>3</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-2-67</b>  |
| 9. AGE (In years last birthday)<br><b>1</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>6</b> Hours <b>1</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>---</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |
| 13. FATHER'S NAME<br><b>John William Hall</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Scharon Wink</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>---</b>  |   | 16. SOCIAL SECURITY NO.<br><b>-----</b>   |  |
| 17. INFORMANT<br><b>Hospital records</b>   |   | Address<br><b>Cheverly, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7605</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Possible brain injury</b> DUE TO<br>(c) <b>Respiratory arrest.</b> |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |   |   |  |
| 21. I certify that <del>it</del> (this hospital) attended the deceased from <b>9/2/1967</b> to <b>9/2/1967</b> that <del>it</del> (we) last saw the deceased alive on <b>9/2/1967</b> , and that death occurred at <b>5:30 PM</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><i>Mahdavi</i>   |   | 22b. DATE SIGNED<br><b>Sept. 2, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Mahdavi, M. D.</b>  |   | 22d. ADDRESS<br><b>Prince Georges General Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Sept 5, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Olivet Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D. C.</b> |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |   | ADDRESS<br><b>Hyattsville, Md.</b>  |  |
| 25a. REC'D BY REGISTRAR<br>OATE <b>SEP 8 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |



12558

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Prince George General Hospital  
2110 Spadina Avenue  
Toronto, Ontario

May 1st 1947  
To: The Surgeon General  
From: The Medical Director  
Subject: [Illegible]

Possibly brain injury  
Respiratory arrest

[Illegible text block]

Respiratory arrest  
[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

12844

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12853

|  |                              |   |  |   |  |   |   |
|--|------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>PG</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Clinton</u>   |                              |   |  | c. LENGTH OF STAY IN 1b<br><u>4-2-67-9-11-67</u>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Pine View Gardens, Clinton Md</u>   |                              |   |  | d. STREET ADDRESS<br><u>7443 Glenale Dr</u>   |  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Virginia</u> Middle <u>Mozelle</u> Last <u>Hall</u>   |                              |   |  | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>11</u> Year <u>1967</u>   |  |   |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-5-1910</u>   | 9. AGE (In years lost birthday)<br><u>56</u> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                              |   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>DOMESTIC</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>VIRGINIA</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |
| 13. FATHER'S NAME<br><u>Baltimore</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>NORA Taylor</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                              |   | 16. SOCIAL SECURITY NO.<br><u>231-34-7023</u>  | 17. INFORMANT<br><u>Betty J. Brown, 7443 Glenale Dr. Clinton MD.</u>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>1992</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ABDOMINAL NEOPLASM WITH</u><br>DUE TO<br>(c) <u>GENERALIZED METASTASES</u> |                              |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u> p.m.  |                              |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-2</u> , 1967, to <u>9-11</u> , 1967, that (I) (we) last saw the deceased alive on <u>9-11</u> , 1967, and that death occurred at <u>1:00 PM</u> , from causes and on the date stated above.   |                              |   |  |   |  |   |   |
| 22a. SIGNATURE<br><u>Alfred R. Lapin</u> M.D.  |                              |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><u>9-11-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ALFRED R. LAPIN, MD</u>   |                              |   |  | 22d. ADDRESS<br><u>CLINTON, MD</u>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 23b. DATE THEREOF<br><u>9-12-67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>TRINITY MEMORIAL</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>WALDORF, CHARLES, MD.</u> |   |
| 24. FUNERAL DIRECTOR<br><u>HUNT FUNERAL HOME, WALDORF, MD.</u>   |                              |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 13 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                            |   |

100

4 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12845

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12854

|  |                               |  |                                     |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>       |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                               | c. LENGTH OF STAY IN 1b <b>DOA</b>   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print) <b>Early Mack Harriston</b>  |                               | 4. DATE OF DEATH <b>9 13 19 67</b>   |                                     |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>5 June 1905</b> |
| 9. AGE (In years lost birthday) <b>62</b> yrs.   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                     |
| 13. FATHER'S NAME <b>John P. Hairston</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Betty Hairston</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>  |                               | 16. SOCIAL SECURITY NO.  |                                     |
| 17. INFORMANT <b>Elaine Parker</b>   |                               | Address  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b><br>DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____   |                               | INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>unknown</b>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                     |
| ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> M.D.  |                               | 22. DATE SIGNED <b>9-13-67</b>   |                                     |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b> Riverdale, Md.  |                               | Address (Street, city, town, or county)  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>9/15/67</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>Martinsville, Va.</b>   |                                     |
| 24. FUNERAL DIRECTOR <b>Greene Funeral Home, Alexandria, Va.</b>   |                               | 25a. REC'D BY REGISTRAR <b>SEP 15 1967</b>   |                                     |
| ADDRESS  |                               | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |                                     |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12846

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12855

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>b. STATE <b>Maryland</b> c. COUNTY <b>Prince George's</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Suitland</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Andrews Air Force Base Hosp.</b>  |                                  |   | d. STREET ADDRESS<br><b>Wye Oak Court</b>  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ruth</b> Middle <b>Jane</b> Last <b>Hayden</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>21</b> Year <b>19 67</b>   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>15 Jan. 1897</b>  |  | 9. AGE (In years lost birthday)<br><b>70</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>           |   |
| 13. FATHER'S NAME<br><b>Thomas Burnham</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Louise Combs</b>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><b>Ernest A. Preston Same As # 2</b>          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b><br>DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____   |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes over 4 yrs.</b>                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |
|  |                                  | 20f. (City or town)   |  | (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe, M.D.</b>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | 22. DATE SIGNED<br><b>9-22-67</b>                                      |   |
| EXAMINER'S NAME (Type)<br><b>John Kehoe, M.D. Riverdale, Md.</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>            |   |
|  |                                  | Address (Street, city, town, or county)   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/26/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>          |   |
|  |                                  | 23d. LOCATION (City or Town)<br><b>Parsons, Kansas</b>  |  | (County) (State)   |   |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm Funeral Home</b><br><b>4308 Suitland Road, Suitland, Maryland</b>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 1967</b>                     |   |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |   |

4000 Building Road, Bellingham, Washington  
Robert T. Wilson, General Agent  
Calvary Cemetery  
Bellingham, Washington

Street A, Bellingham, Bellingham, Bellingham

Thomas Bellingham

Bellingham

My Bellingham

My Bellingham

My Bellingham



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12847

CERTIFICATE OF DEATH

12856

|  |                           |  |                                       |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>P. G</u>                        |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>318 2nd Street</u>   |                           | d. STREET ADDRESS <u>318 2nd Street</u>  |                                       |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM BOYD HIETT</u>  |                           | 4. DATE OF DEATH Month <u>SEPT.</u> Day <u>3</u> Year <u>19 67</u>   |                                       |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 17, 1890</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs.   |                           | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>linesman</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>gas &amp; electric</u>  |                                       |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                       |
| 13. FATHER'S NAME <u>James B Hiett</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Jennie Swanden</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WWI</u>   |                           | 16. SOCIAL SECURITY NO. <u>212-05-5814</u>   |                                       |
| 17. INFORMANT <u>Mrs Wm B Hiett Laurel Md</u>  |                           | Address <u>952 Mantua St</u>   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u><br>DUE TO (c) <u>Arteriosclerosis</u> |                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u><br><u>1 yr</u><br><u>15 yr</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 hypertension</u>  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> , 19 <u>53</u> , to <u>9/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/2</u> , 19 <u>67</u> , and that death occurred at <u>3A</u> M, from causes and on the date stated above.   |                           |  |                                       |
| 22a. SIGNATURE <u>J M Warren</u>   |                           | 22b. DATE SIGNED   |                                       |
| 22c. PHYSICIAN'S NAME (Type) <u>J M Warren</u>   |                           | 22d. ADDRESS <u>Laurel, Md.</u>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 23b. DATE/THEREOF <u>9/6/67</u>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Ans Hill Cem</u>   |                           | 23d. LOCATION (City or Town) (County) (State) <u>Laurel P.G Md</u>   |                                       |
| 24. FUNERAL DIRECTOR <u>Wm Witt Danasdan Laurel Md</u>   |                           | 25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>   |                                       |
| ADDRESS  |                           | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                                       |

100-100000

MEMORANDUM FOR THE DIRECTOR

100-100000

TO :

FROM :

SUBJECT :

DATE :

RE :

BY :

FOR :

THRU :

FILE :

NOTED :

REMARKS :

APPROVED :

SPECIAL AGENT IN CHARGE

DATE :

RE :

BY :

FOR :

THRU :

FILE :

NOTED :

REMARKS :

APPROVED :

SPECIAL AGENT IN CHARGE

DATE :

100-100000

1

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322 UCBAW/STP

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12848

**CERTIFICATE OF DEATH**

12857

|  |                                  |  |  |   |   |  |                  |
|--|----------------------------------|--|--|---|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Prince Georges County MARYLAND</i>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>MARYLAND</i> b. COUNTY <i>Pr. Geo.</i> |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Clinton, Md</i>   |                                  | c. LENGTH OF STAY IN 1b<br><i>2 1/2 mos.</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>CLINTON</i>  |   |  |                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Pine View Garden, Clinton, Md</i>   |                                  |  |  | d. STREET ADDRESS<br><i>RFD Box 665</i>   |   | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><i>Francis Clyde Higdon</i>  |                                  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><i>9-24-1967</i>  |   |  |                  |
| 5. SEX<br><i>M.</i>  | 6. COLOR OR RACE<br><i>Cauc.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>March 10 1884</i> | 9. AGE (In years last birthday)<br><i>83 yrs.</i>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Farmer</i>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                  |
| 13. FATHER'S NAME<br><i>Louis Higdon</i>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><i>Thomas</i>   |   |  |                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |                                  | 16. SOCIAL SECURITY NO.<br><i>577-18-5277</i>  |  | 17. INFORMANT<br><i>Minnie A. Snellings</i> Address <i>same as #2.</i>  |   |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>2041</i> <b>TERMINAL BRONCHOPNEUMONIA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC MYELOCYTIC LEUKEMIA</b><br>DUE TO<br>(c) |                                  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>24 HRS.</i><br><i>1 YR.</i>                             |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>ARTERIO-SCLEROTIC CARDIO-VASCULAR DIS- WITH ANGINA</i><br><i>WITH CONGESTIVE FAILURE</i>   |                                  |  |  |   |   |  |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><i>None</i>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)<br><i>None</i>   |  |   |   |  |                  |
| 20c. TIME OF INJURY Month, Day, Year<br><i>None</i> 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><i>None</i>   |   | 20f. (City or town) (County) (State)<br><i>None</i>  |                  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 8</i> , 19 <i>64</i> , to <i>present</i> that (I) ( <i>we</i> ) last saw the deceased alive on <i>9/23</i> 19 <i>67</i> , and that death occurred at <i>6:45 PM</i> , from causes and on the date stated above.  |                                  |  |  |   |   |  |                  |
| 22a. SIGNATURE<br><i>Arthur Shaver Jr.</i>   |                                  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |   | 22b. DATE SIGNED<br><i>9/24/67</i>   |                  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>ARTHUR SHAVER JR.</i>   |                                  |  |  | 22d. ADDRESS<br><i>8808 BRANCH AVE. CLINTON, MD.</i>  |   |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 23b. DATE THEREOF<br><i>Sept. 26-1967</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>  |   | 23d. LOCATION (City or town) (County) (State)<br><i>Suitland, Maryland</i>                     |                  |
| 24. FUNERAL DIRECTOR<br><i>Simmons Bros.</i>   |                                  |  |  | ADDRESS<br><i>1661-Gd. Hope RD. SE. Wash., DC</i>   |   | 25a. REC'D BY REGISTRAR<br><i>SEP 26 1967</i>  |                  |
|  |                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |  |                  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF NEW YORK, DEPARTMENT OF HEALTH

IN SENATE, JANUARY 1, 1910

Attest, I, the undersigned, being a duly qualified medical officer of health for the City and County of New York, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the Department of Health.

Witness my hand and the seal of the Department of Health at New York, this 1st day of January, 1910.

JOHN W. WATSON, M.D.,  
Medical Officer of Health for the City and County of New York.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12849

12858

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Ind</u> b. COUNTY <u>Pro Geo.</u>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>LANHAM MD.</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Mt Rainier, Ind</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>MAGNOLIA GARDENS NURS. HOME</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SADIE</u> Middle <u>C.</u> Last <u>HILDEBRAND</u>   |  | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>25</u> Year <u>1967</u>  |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/27/1883</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 9. AGE (In years lost birthday)<br><u>83</u> yrs.  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>?</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Renetta Layman</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u><br><u>334X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u><br>DUE TO (c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u><br><u>15 yrs.</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <del>the</del> (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>66</u> , to <u>Sept 25</u> , 19 <u>67</u> , that <del>we</del> (we) last saw the deceased alive on <u>Sept 25</u> , 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.                        |  |   |  |
| 22a. SIGNATURE<br><u>Thomas G. Maloney</u> M.D.   |  | 22b. DATE SIGNED<br><u>25 Sept 67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>THOMAS G. MALONEY</u>  |  | 22d. ADDRESS<br><u>4814-71st, WOODLAWN, MD.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>Sept 28, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt View Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Waynesboro Augusta Va</u>                  |
| 24. FUNERAL DIRECTOR<br><u>F. Gasch's Sons</u>  |  | 25a. REC'D BY REGISTRAR<br><u>SEP 27 1967</u>   |  |
| ADDRESS<br><u>Hyattsville, Md.</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-1-58

CERTIFICATE OF DEATH

1-1-58

1. Name of deceased: JOHN J. HEDDERLEY

2. Sex: Male

3. Race: White

4. Date of birth: 1-1-1901

5. Place of birth: St. Louis, Mo.

6. Date of death: 1-1-1958

7. Place of death: St. Louis, Mo.

8. Cause of death: Myocardial Infarction

9. Duration of illness: 2 weeks

10. Usual place of abode: St. Louis, Mo.

11. Signature of physician: [Signature]

12. Signature of registrar: [Signature]

13. Date of registration: 1-1-1958

14. Place of registration: St. Louis, Mo.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12850

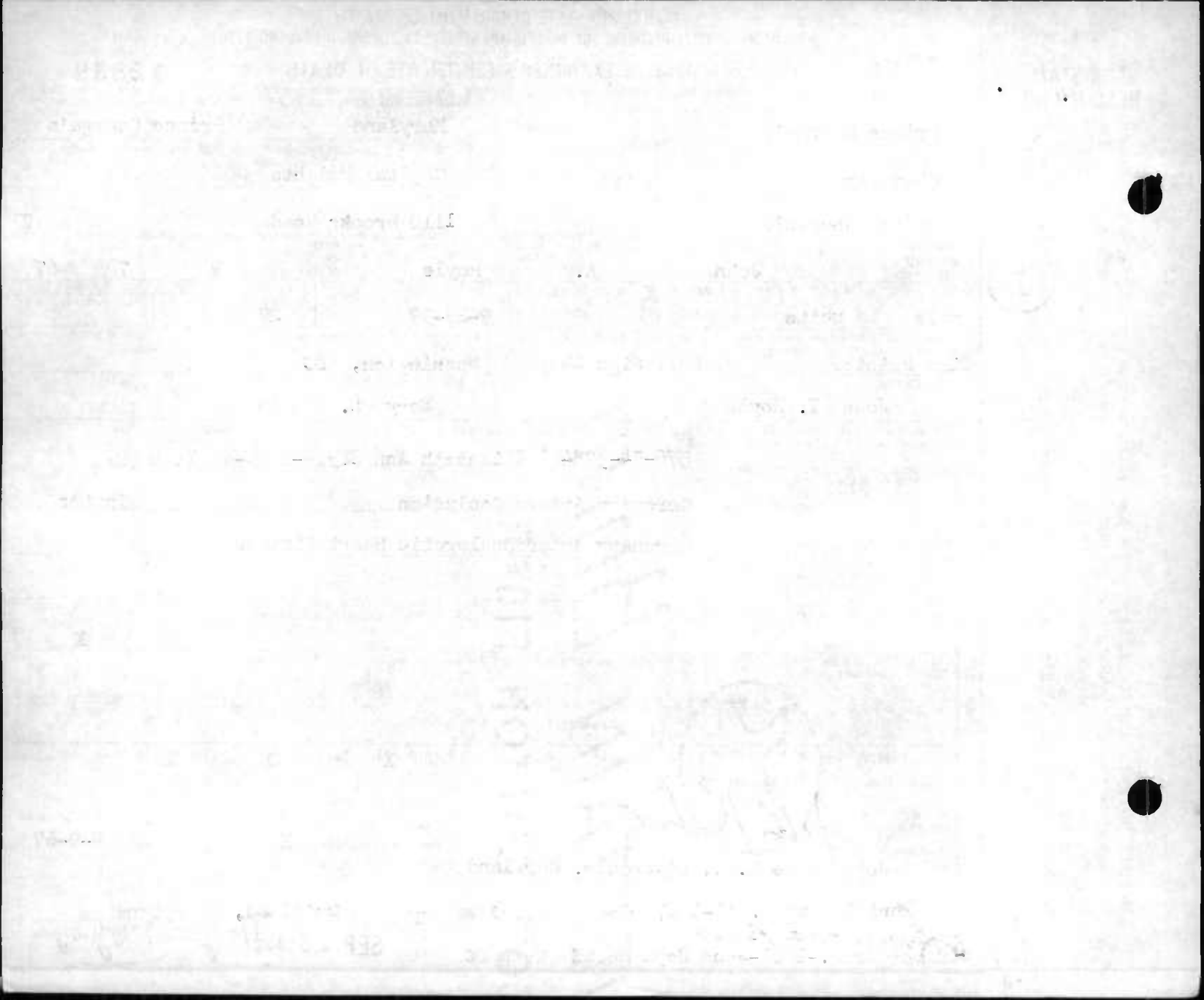
12859

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |   |                                    |  |   |   |  |
|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George's</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's</b>  |                                  |   |                                    | d. STREET ADDRESS<br><b>1110 Brooks Road</b>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>A.</b> Last <b>Hoyle</b>   |                                  |   |                                    | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>7</b> Year <b>19 67</b>  |   |   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-23-39</b> |  | 9. AGE (In years last birthday)<br><b>27</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sign Painter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Duff Sign Shop</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, DC</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>John V. Hoyle</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Mary L. Dustin</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>678-54-3284</b>   |                                    | 17. INFORMANT<br><b>Elizabeth Ann Hoyle-Same-as Item #2</b> Address  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Occlusion</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerotic Heart Disease</b><br>DUE TO (c)   |                                  |   |                                    |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |                                    |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                    |  |   |   |  |
| ACTUAL SIGNATURE<br><i>John Kehoe</i><br>EXAMINER'S NAME (Type)<br><b>John Kehoe M.D., Riverdale, Maryland</b>  |                                  |   |                                    | 22. DATE SIGNED<br><b>9-9-67</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE THEREOF<br><b>Sept. 11-1967</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>Simmons Bros.</b> ADDRESS<br><b>Simmons Bros.-1661-Good Hope Rd SE Wash DC</b>   |                                  |   |                                    | 25a. REC'D BY REGISTRAR<br><b>SEP 13 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12851

12860

|   |                                  |   |   |  |   |  |   |
|---|----------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George's</b>   |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Leland Memorial Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>7360 Landover Road</b>   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Nancy M Irwin</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>9 7 19 67</b>   |   |  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb 24, 1944</b>                   | 9. AGE (In years last birthday)<br><b>23</b> yrs.  | 10. UNDER 1 YEAR<br>Months Days                         |  | 10. UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Paper Company</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |
| 13. FATHER'S NAME<br><b>John H Gaver</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Crilly</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>37756 9038</b>  |   | 17. INFORMANT<br><b>Elmer H Irwin</b> Address<br><b>Hyattsville, Md.</b>   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastric hemorrhage</b><br><b>7845</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown</b> DUE TO<br>(c) _____  |                                  |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |  |   |
| ACTUAL SIGNATURE<br><i>John Kehoe</i><br>EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>   |                                  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   |  |   |
| 22. DATE SIGNED<br><b>9-9-67</b>  |                                  |   |   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Sept 11, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><b>Ft Lincoln Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Pro Geo Md.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b> ADDRESS<br><b>Hyattsville, Md.</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 13 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. [unclear]</i>                        |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12852

12861

|   |                                 |   |   |
|---|---------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Delaware</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   |
|   |                                 | <b>Dover</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>U.S.A.F. Hospital Andrews A.F.B.</b>   |                                 | d. STREET ADDRESS<br><b>3205 Cypress St., Dover, Del.</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                 |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>D.</b> Last <b>Jackson</b>   |                                 | 4. DATE OF DEATH<br>Month <b>9-</b> Day <b>30</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Cau.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-13-1922</b>                                  |
| 9. AGE (In years last birthday)<br><b>45</b> yrs.   |                                 | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Soldier</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Military</b>  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Indiana</b> |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                 |   |   |
| 13. FATHER'S NAME<br><b>William Jackson</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Zella Wray</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes</b> <b>1943-48-67</b>   |                                 | 16. SOCIAL SECURITY NO.<br><b>310-16-4078</b>   |   |
| 17. INFORMANT   |                                 | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia and Hemorrhages</b><br>DUE TO<br>(b) <b>Adenocarcinoma of the right lung</b><br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                 | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                 | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.  |                                 |   |   |
| 22a. SIGNATURE<br><b>[Signature]</b>  |                                 | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)  |                                 | 22d. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                 | 23b. DATE THEREOF   |   |
| <b>5 Oct 67</b>   |                                 | <b>Clear water</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY  |                                 | 23d. LOCATION (City or Town) (County) (State)   |   |
| <b>Bloomington</b>  |                                 | <b>Indiana</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>[Signature]</b>  |                                 | 25a. REC'D BY REGISTRAR   |   |
| <b>Federalsburg, Md.</b>  |                                 | <b>OCT 6 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                 |   |   |

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*Journal of Interpersonal Violence*

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12853

12862

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Charles Clarke Jewell</b>   |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>9 5 19 67</b>  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3-29-1912</b>   |  |
| 9. AGE (In years last birthday)<br><b>55</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Refrigeration Mechanic</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Winchester, Maryland</b>       |  |
| 13. FATHER'S NAME<br><b>George Jewell</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ruby Eaton</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>577-22-7673</b>   |  | 17. INFORMANT<br><b>Mrs. C. Clarke Jewell--Stevensville</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b><br>DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes over 9 mo.</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                 |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work                 |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>John Vehoe, M.D. Riverdale, Md.</b>  |  |  |  | 22. DATE SIGNED<br><b>9-5-67</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>Sept. 7</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Stevensville</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Stevensville, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Alyce R. Lane</b>   |  |  |  | ADDRESS<br><b>Church Hill, Maryland</b>   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 7 1967</b>                                   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12854

12863

FOR STATE  
HEALTH DEPT.

|   |                               |  |                                     |  |   |  |  |
|---|-------------------------------|--|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                               |  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |                               |  |                                     | c. LENGTH OF STAY IN 1b <b>DOA</b>   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>  |                               |  |                                     | d. STREET ADDRESS <b>9401 Fontana Drive</b>  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alice</b> Middle <b>Sophia</b> Last <b>Jones</b>  |                               |  |                                     | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>13</b> Year <b>19 67</b>   |   |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>5 Oct. 1891</b> | 9. AGE (In years lost birthday) <b>75</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>16</b> Days <b>1</b> | IF UNDER 24 HRS.<br>Hours <b>1</b> Min. <b>67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |                                     | 11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |
| 13. FATHER'S NAME <b>Edward T. Stunkel</b>  |                               |  |                                     | 14. MOTHER'S MAIDEN NAME <b>Jessie G. Stunkel</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <b>579-24-0364D</b>  |                                     | 17. INFORMANT Address <b>Carleton T. Jones, Jr. Burtonsville, Md.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>(c) _____  |                               |  |                                     |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>unknown</b>                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                     |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |  |                                     |  |   |  |  |
| ACTUAL SIGNATURE <b>John Kehoe</b>  |                               | M.D. <b>John Kehoe, M.D. Riverdale, Md.</b>  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED <b>9-14-67</b>   |  |
| EXAMINER'S NAME (Type)  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>Sept. 15, 1967</b>  |                                     | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, P. G. Md.</b>                   |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Maryland</b>   |                               |  |                                     | 25a. REC'D BY REGISTRAR <b>SEP 19 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1943

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Pages 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Md. b. COUNTY Prince George   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Heights 16-1  |  |
| c. LENGTH OF STAY IN Ib DOA   |  | d. STREET ADDRESS 1700 Kenilworth Ave.,   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last Christopher Jones   |  | 4. DATE OF DEATH Month Day Year 9 22 19 67  |  |
| 5. SEX F  | 6. COLOR OR RACE Negro   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH 14 July, 1967   |
| 9. AGE (In years lost birthday) yrs. 2 10   |  | IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none  |  | 10b. KIND OF BUSINESS OR INDUSTRY none  |  |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C.  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |
| 13. FATHER'S NAME Willie Jones  |  | 14. MOTHER'S MAIDEN NAME Virginia McNeil  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no  |  | 16. SOCIAL SECURITY NO. no  |  |
| 17. INFORMANT Willis Jones  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Undetermined 7955<br>DUE TO (b) SDII<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) |  |
| 22. DATE SIGNED 9-23-67   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF 9-26-67  | 23c. NAME OF CEMETERY OR CREMATORY Laurel   | 23d. LOCATION (City or Town) (County) (State) Culpeper Va.                                     |
| 24. FUNERAL DIRECTOR William M. Marshall  |  | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12856

12865

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>                      |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>DOA</u>   |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>   |  |   |  | d. STREET ADDRESS <u>3206 Wisconsin Ave., N.W.</u>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Helga</u> Middle <u>Kempka</u> Last <u>Kempka</u>  |  |   |  | 4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1967</u>   |  |  |   |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 8. DATE OF BIRTH <u>10-12-1919</u>   |   |
| 9. AGE (In years last birthday) <u>47</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>New York</u>                                |   |
| 13. FATHER'S NAME <u>Thorwald Lauridsen</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Laura Neilson</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>- - -</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>- - -</u>   |  | 17. INFORMANT Address <u>Pelham, N.Y.</u><br><u>Harold Lauridsen -937 Split Rock Rd.</u> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Laceration of brain</u><br>DUE TO (b) <u>Fracture of skull</u><br>DUE TO (c) <u>Auto Accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>823.4</u>  |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car which went out of control and overturned.</u>                 |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year <u>1:03 am 9 24 19 67</u>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> |  |  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Balt. Wash. Parkway</u>  |  |   |  | 20f. (City or town) (County) (State) <u>Anne Arundel Co., Md.</u>  |  |  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |   |
| ACTUAL SIGNATURE <u>John Kehoe</u>   |  |   |  | 22. DATE SIGNED <u>9-24-67</u>   |  |  |   |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u>  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>   |  | 23b. DATE THEREOF <u>9-27-1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>                       |   |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>   |  |   |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |  |   |
| ADDRESS <u>5130 Wisc. Ave. N.W., Wash. DC</u>  |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |   |
| DATE <u>OCT 3 1967</u>   |  |   |  |  |  |  |   |



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12866

12857

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>                |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |  |  |  | c. LENGTH OF STAY IN 1b <b>DOA</b>   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Elsie R Kilpatrick</b>   |  |  |  | 4. DATE OF DEATH <b>9 12 19 67</b>   |  |  |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>7 April 1933</b>                                   |  |  |  |
| 9. AGE (In years lost birthday) <b>34</b> yrs.  |  | 10. IF UNDER 1 YEAR Months <b>34</b> Days <b>34</b> Hours <b>34</b> Min. |  | 11. BIRTHPLACE (State or foreign country) <b>Corcoran Penna</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                |  |  |  |
| 13. FATHER'S NAME <b>ARTHUR F. SIMMONS</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>SUSIE</b>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>166-26-7536</b>   |  | 17. INFORMANT <b>EDUARDE KILPATRICK</b> Address <b>SAME AS #2-</b>     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7955</b> IMMEDIATE CAUSE (a) <b>Undetermined</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>7955</b> DUE TO (c) <b>7955</b>   |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b><br>Hour a.m. <b>19</b> p.m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |  |  |
| 20f. (City or town) (County) (State)  |  |  |  | 20g. (City or town) (County) (State)   |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 22. ACTUAL SIGNATURE <b>John Kehoe</b> M.D.   |  |  |  | 22. DATE SIGNED <b>9-13-67</b>   |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>  |  |  |  | Address (Street, city, town, or county) <b>Riverdale, Md.</b>  |  |  |  |  |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)   |  | 23b. DATE THEREOF <b>Sept 18/67</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LAMPHIER CEM.</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>ELDRIDGE PENNA.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Charles Judge</b>   |  |  |  | 25. REC'D BY REGISTRAR <b>Charles Judge</b>  |  |  |  |  |  |
| ADDRESS <b>550 WASH BLVD</b>  |  |  |  | DATE <b>SEP 18 1967</b>  |  |  |  |  |  |



*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "Lecture" and "Lecture" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12858

CERTIFICATE OF DEATH

12867

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Mt Rainier</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>yes.</u>   |  |  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>MOUNT RAINIER</u>  |  |   |  | 16-1   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>3103 Bunker Hill Road</u>  |  |   |  | d. STREET ADDRESS<br><u>3103 BUNKER HILL ROAD</u>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>CHARLES P KNOWLES</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>September</u> Day <u>2</u> Year <u>1967</u>   |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><u>January 19 1886</u>   |  |
| 9. AGE (In years last birthday)<br><u>81</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |  | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Union Trustee # 67</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u></u>   |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Washington DC.</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |  |  |
| 13. FATHER'S NAME<br><u>David O Knowles</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>MARY HOGAN</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>577 09 8726</u>  |  | 17. INFORMANT <u>SISTER</u><br><u>MARGARET E Knowles</u> Address <u>SAME AS ABOVE.</u> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Left Ventricular Failure</u><br>DUE TO (b) <u>Pulmonary Emphysema</u><br>DUE TO (c) <u>Arteriosclerosis, Heart Disease</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u></u>  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u></u> o.m. <u></u> p.m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                 |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/13/</u> 19 <u>67</u> , to <u>9/2/</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/31/</u> 19 <u>67</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above.                        |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>E. Stuart Lyddane</u>  |  |   |  | 22b. DATE SIGNED<br><u>9/2/67</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>E. STUART LYDDANE</u>                               |  |
| 22d. ADDRESS<br><u>3066 - Quaker, Md.</u>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| <u>Burial</u>   |  | <u>9-6-1967</u>   |  | <u>Holy Road Cemetery</u>  |  | <u>Washington DC.</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>NALLEY Funeral Home</u>  |  |   |  | 25a. REC'D BY REGISTRAR<br><u>SEP 8 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12859

## CERTIFICATE OF DEATH

12868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                              |   |  |   |   |  |   |
|---|------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> <b>MARYLAND</b>   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u> |   |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>LAUREL</u>   |                              |   |  | c. LENGTH OF STAY IN 1b<br><u>Bowie</u>   |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>LAUREL General Hospital</u>  |                              |   |  | d. STREET ADDRESS<br><u>Route 1 Box 101</u>   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Stephen C LANHAM SR</u>  |                              |   |  | 4. DATE OF DEATH Month Day Year<br><u>Sept. 10 1967</u>   |   |  |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>8/8/1894</u>   | 9. AGE (In years last birthday)<br><u>73</u> yrs. | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>store keeper</u>  |                              |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>owner</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>P.G. Co. Md.</u>     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                              |   |  | 13. FATHER'S NAME<br><u>Stephen C Lanham SR</u>   |   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Margaret R. Baldwin</u>  |                              |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>                    |   |  |   |
| 16. SOCIAL SECURITY NO.<br><u>217 03 5266</u>   |                              |   |  | 17. INFORMANT<br><u>Helen L. Lanham, Bowie, Md.</u>   |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure, Metastatic Carcinoma</u><br><u>157X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>carcinoma of pancreas metastasis</u><br>(c) <u>same</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>same</u> |                              |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m.<br><u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> 19 <u>67</u> to <u>9-10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-9</u> 19 <u>67</u> , and that death occurred at <u>9:00</u> A.M. from the causes and on the date stated above.  |                              |   |  |   |   |  |   |
| 22a. SIGNATURE<br><u>Idolo Pierandrew</u> M.D.  |                              |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |   | 22b. DATE SIGNED<br><u>9-10-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>IDOLO PIERANDREW</u>   |                              |   |  | 22d. ADDRESS<br><u>Laurel Md.</u>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE THEREOF<br><u>Sept 13, 1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>White Marsh Cemetery</u>   |   | 23d. LOCATION (City, town or county) (State)<br><u>White Marsh Pro Geo Md.</u> |   |
| 24 FUNERAL DIRECTOR'S SIGNATURE<br><u>F. Gasch's Sons</u>   |                              |   |  | ADDRESS<br><u>Hyattsville, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 14 1967</u>                             |   |
|   |                              |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |  |   |

1985

8 1  
3  
FOR STATE HEALTH DEPT (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12869

|  |                               |   |  |  |  |  |  |
|--|-------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b><br>b. COUNTY |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                               |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>                           |  |  |  |
| c. LENGTH OF STAY IN 1b <b>DOA</b>   |                               |   |  | d. STREET ADDRESS <b>3042 Patrick Henry Drive</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>   |                               |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>James</b> Middle <b>Richard</b> Last <b>Lawrence</b>   |                               |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>26</b> Year <b>19 67</b>   |  |  |  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>30 Oct. 1939</b>   |  | 9. AGE (In years lost birthday) <b>27</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>   |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Lawrence, Penna</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |
| 13. FATHER'S NAME <b>Mike M. Lawrence</b>  |                               |   | 14. MOTHER'S MAIDEN NAME <b>Mary Vulcer</b>  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>   |                               |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <b>Sandra L. Lawrence (wife)</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CRUSHING INJURY TO CHEST</b><br><b>9123</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>AND ABDOMEN</b><br>DUE TO (c) <b>and LACERATION OF BRAIN</b>  |                               |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Run over by tractor.</b> |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>9:50am</b> p.m. <b>9-26- 19 67</b>  |                               |   | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>        |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Construction site, Prince George Hosp.</b> |  |  |
| 20f. (City or town) <b>Cheverly, Md.</b> (County) (State)  |                               |   |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Naturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> |                               |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.  |                               |   | 22. DATE SIGNED <b>9-26-67</b>   |  |  |  |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>  |                               |   | Address (Street, city, town, or county)  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>Sept. 29, 67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Memorial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>Burke, Virginia</b> |  |
| 24. FUNERAL DIRECTOR <b>Covington-Martin Funeral Home</b>  |                               |   |  | 25a. REC'D BY REGISTRAR <b>6161 Leesburg Pike Falls Church, Va.</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>                    |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12870

|  |                                  |   |  |  |  |
|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>  |                                  |   | c. LENGTH OF STAY IN 1b <b>DOA</b>   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chamber's Funeral Home</b>   |                                  |   | d. STREET ADDRESS <b>University Park</b><br><b>6724 Baltimore Blvd.</b>  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Edinger</b> Last <b>Linch</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>15</b> Year <b>19 67</b>   |  |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>1-6-1912</b>   |  | 9. AGE (In years lost birthday) <b>55</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. MARINE CORPS.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <b>CONN.</b>                                     |  |
| 13. FATHER'S NAME <b>EDWARD P. LINCH</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME <b>MABLE EDDINGER</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW II</b>  |                                  | 16. SOCIAL SECURITY NO. <b>186-01-8543</b>  |  | 17. INFORMANT <b>MRS. KATHLEEN LINCH</b> Address <b>108 TROY LANE KING OF PRUSSIA, PA.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____   |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>unknown</b>                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |  |  |
| ACTUAL SIGNATURE <b>John Kehoe</b>   |                                  | M.D.  |  | 22. DATE SIGNED <b>9-18-67</b>   |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>   |                                  | <b>Riverdale, Md.</b>   |  | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>   | 23b. DATE THEREOF <b>9-26-67</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, MD.</b>                      |  |
| 24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO.</b>  |                                  | ADDRESS <b>RIVERDALE, MD.</b>   |  | 25a. REC'D BY REGISTRAR <b>SEP 28 1967</b>   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |



1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Phone: [illegible]  
7. Date: [illegible]  
8. Signature: [illegible]

9. [illegible]  
10. [illegible]  
11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]  
16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12862

CERTIFICATE OF DEATH

12871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                              |   |                                      |
|--|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <u>PRINCE GEORGE</u> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>                  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CLINTON</u>   |                              | c. LENGTH OF STAY IN lb<br><u>8-7-67-9-30-67</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>PINEVIEW GARDENS</u>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - CHARLOTTE HALL</u>   |                                      |
|  |                              | d. STREET ADDRESS<br><u>082</u>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARY</u> Middle <u>E</u> Last <u>LONG</u>  |                              | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>30</u> Year <u>1967</u>   |                                      |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-17-1882</u> |
| 9. AGE (In years last birthday)<br><u>85</u> yrs.  |                              | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                      |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |                              | 12. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>  |                                      |
| 13. BIRTHPLACE (County & State, or foreign country)<br><u>CHARLES COUNTY, MARYLAND</u>   |                              | 14. CITIZEN OF WHAT COUNTRY?<br><u>  </u>   |                                      |
| 15. FATHER'S NAME<br><u>JOHN G. FARR</u>   |                              | 16. MOTHER'S MAIDEN NAME<br><u>CATHERINE R. DAVIS</u>   |                                      |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                              | 18. SOCIAL SECURITY NO.<br><u>217-36-8642</u>   |                                      |
| 19. INFORMANT<br><u>James Judson Long-Son-Charlotte Hall</u>   |                              | Address<br><u>  </u>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Hypertension</u><br>DUE TO (c) <u>Arteriosclerotic disease</u> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Fractured Left Femur</u>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |                              | 20f. (City or town) (County) (State)<br><u>  </u>   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-7-1967</u> to <u>9/30-1967</u> that (I) (we) lost the deceased alive on <u>9/30-1967</u> and that death occurred at <u>5:30</u> M, from causes and on the date stated above.  |                              |   |                                      |
| 22a. SIGNATURE<br><u>Alfred R. Lapina</u>  |                              | 22b. DATE SIGNED<br><u>9-30-67</u>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ALFRED R. LAPINA, MD</u>  |                              | 22d. ADDRESS<br><u>CLINTON, MD</u>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>10/3/1967</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Mary's Cemetery</u>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><u>Newport, Maryland</u>   |                                      |
| 24. FUNERAL DIRECTOR<br><u>ARCHART FUNERAL HOME</u>  |                              | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                              | DATE<br><u>OCT 4 1967</u>   |                                      |

1941

UNITED STATES OF AMERICA

1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

12863

Item #2a,b,c & d Film #G393 10/11/67 ph

# CERTIFICATE OF DEATH

12872

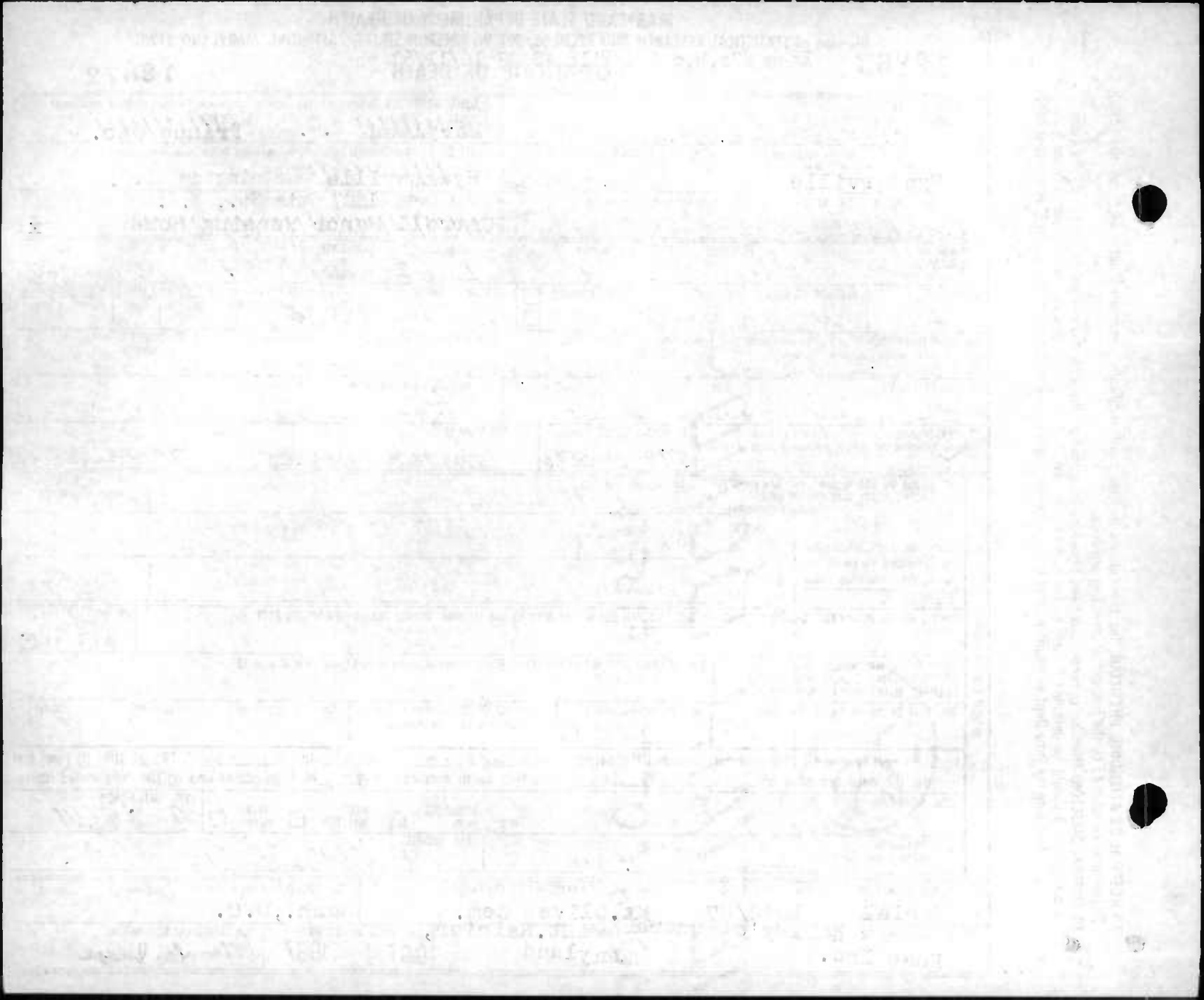
|   |                               |   |   |  |  |   |  |
|---|-------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGES</u> MARYLAND   |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>10 months 13 days</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hyattsville / Washington D.C.</u> <u>473</u>            |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>CARROLL MANOR</u>  |                               |   |   | d. STREET ADDRESS <u>1007 Otis St., N.E.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>ESTELLE</u> Middle <u>H.</u> Last <u>LUCAS</u>   |                               |   |   | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>29</u> Year <u>19 67</u>   |  |   |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 24 1880</u> | 9. AGE (In years lost birthday)<br><u>86</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Clerical Supervisor</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Government</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>WASHINGTON, D.C.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>ZACHARY TAYLOR HUNT.</u>  |                               |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Katherine WARD.</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes <input checked="" type="checkbox"/> no <input type="checkbox"/> or unknown)   |                               | 16. SOCIAL SECURITY NO.<br><u>579-60-5126</u>   |   | 17. INFORMANT<br>Address <u>Sister DOLORES. CARROLL MANOR.</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u><br><u>332x</u><br>DUE TO <u>Generalized + cerebral arteriosclerosis.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>DUE TO <u>  </u><br>(c) <u>Coronary arteriosclerosis</u> |                               |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs.</u><br><u>2 yrs.</u>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><u>Coronary Heart failure + Diabetes</u>   |                               |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1967</u> , to <u>Sept 29, 1967</u> , that (I) (we) lost the deceased alive on <u>Sept 29, 1967</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above.  |                               |   |   |  |  |   |  |
| 22a. SIGNATURE<br><u>Richard F. Shaw</u>  |                               |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                |  | 22b. DATE SIGNED<br><u>9-29-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>RICHARD F. SHAW</u>  |                               |   |   | 22d. ADDRESS<br><u>1324 Michigan Ave. U.S.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 23b. DATE THEREOF<br><u>10/2/67</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cem.</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Wash., D.C.</u>                               |  |
| 24. FUNERAL DIRECTOR<br><u>Nalley's Funeral Home Inc.</u>   |                               |   |   | ADDRESS <u>Mt. Rainier Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>4</u> 1967   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>R Charles Judge</u>  |                               |   |   |  |  |   |  |

MEDICAL CERTIFICATION

2

90

1





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12864

CERTIFICATE OF DEATH

12873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |  |   |   |  |
|--|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>2 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b><br>d. STREET ADDRESS<br><b>5011 Indian Lane</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>David R. Luxen</b>  |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>23 Sept. 1967</b>   |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 5, 1895</b> | 9. AGE (In years last birthday)<br><b>71</b> yrs.  | IF UNDER 1 YEAR<br>Months Days<br><b>16-1</b> |   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Watchman</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Motel</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington D. C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                      |  |
| 13. FATHER'S NAME<br><b>- Luxen</b>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>579 14 6047</b>   |   | 17. INFORMANT<br><b>Frances Ardelle Wilson</b>   |   | Address<br><b>College Park, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture Aortic Aneurysm.</b><br><b>451X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Retroperitoneal Hemorrhage (750)).</b><br>DUE TO<br>(c) <b>Arteriosclerotic cardiovascular disease.</b> |  |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |   |  |
| 21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>June</b> , 19 <b>67</b> , to <b>Sept. 23</b> , 19 <b>67</b> , that (I) <del>(the)</del> last saw the deceased alive on <b>Sept. 23</b> , 19 <b>67</b> , and that death occurred at <b>5:45 P.</b> from causes on and on the date stated above.  |  |   |   |  |   |   |  |
| 22a. SIGNATURE<br><b>Peter Duus</b>  |  |   |   | 22b. DATE SIGNED<br><b>Sept. 25, 1967</b>  |   | 22c. PHYSICIAN'S NAME (Type)<br><b>Peter Duus, M. D.</b>                          |  |
| 22d. ADDRESS<br><b>6124 Central Ave. Capital Hghts, Md.</b>  |  |   |   | 22e. REC'D BY REGISTRAR<br><b>SEP 27 1967</b>  |   | 22f. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>Sept 27, 1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor, Pro Geo Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |  |   |   | ADDRESS<br><b>Hyattsville, Md.</b>   |   |   |  |



1967-1968

Office of the Surgeon General

Division of Field Operations

Office of the Assistant Surgeon General

Office of the Assistant Surgeon General

Office of the Assistant Surgeon General

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12865

12874

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |   |   |   |   |   |                                  |
|--|----------------------------------|---|---|---|---|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>                    |   |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Camp Springs</b>  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Camp Springs</b>   |   |   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7507 Chesterfield Drive</b>   |                                  |   |   | d. STREET ADDRESS<br><b>7507 Chesterfield Drive</b>   |   |   |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>Gladys</b> Last <b>MacKenzie</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>14</b> Year <b>1967</b>   |   |   |                                  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>21 Jan. 1921</b> |   | 9. AGE (In years lost birthday) yrs.<br><b>46</b> | 10. IF UNDER 1 YEAR<br>Months <b>14</b> Days <b>19</b> Hours <b>67</b> Min. |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Idaho</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |                                  |
| 13. FATHER'S NAME<br><b>Ralph J. Comstock</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret G. Bassett</b>  |   |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Francis R. MacKenzie Same As # 2</b>  |   |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b><br><b>976X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                     |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot self at home</b>                                    |   |   |   |   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>9-14-1967</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Bedroom of home</b>  |   | 20f. (City or town) (County) (State)<br><b>same as #2</b>                   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |   |   |   |                                  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |                                  | EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22. DATE SIGNED<br><b>9-15-67</b>   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/17/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mountain View Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocatello, Idaho</b>    |                                  |
| 24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b><br><b>4308 Suitland Road Suitland Maryland</b>  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 18 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                          |                                  |

4308 Suisun Road Suisun, California

Robert E. Smith, Jr.

Walter E. Smith, Jr.

Robert E. Smith, Jr.

John E. Smith, Jr.

Robert E. Smith, Jr.

Robert E. Smith, Jr.

Francis R. Henderson

Louise C. Henderson

Idaho

21 Jan. 1951

Idaho

Idaho

Idaho

Idaho

Idaho

Idaho

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

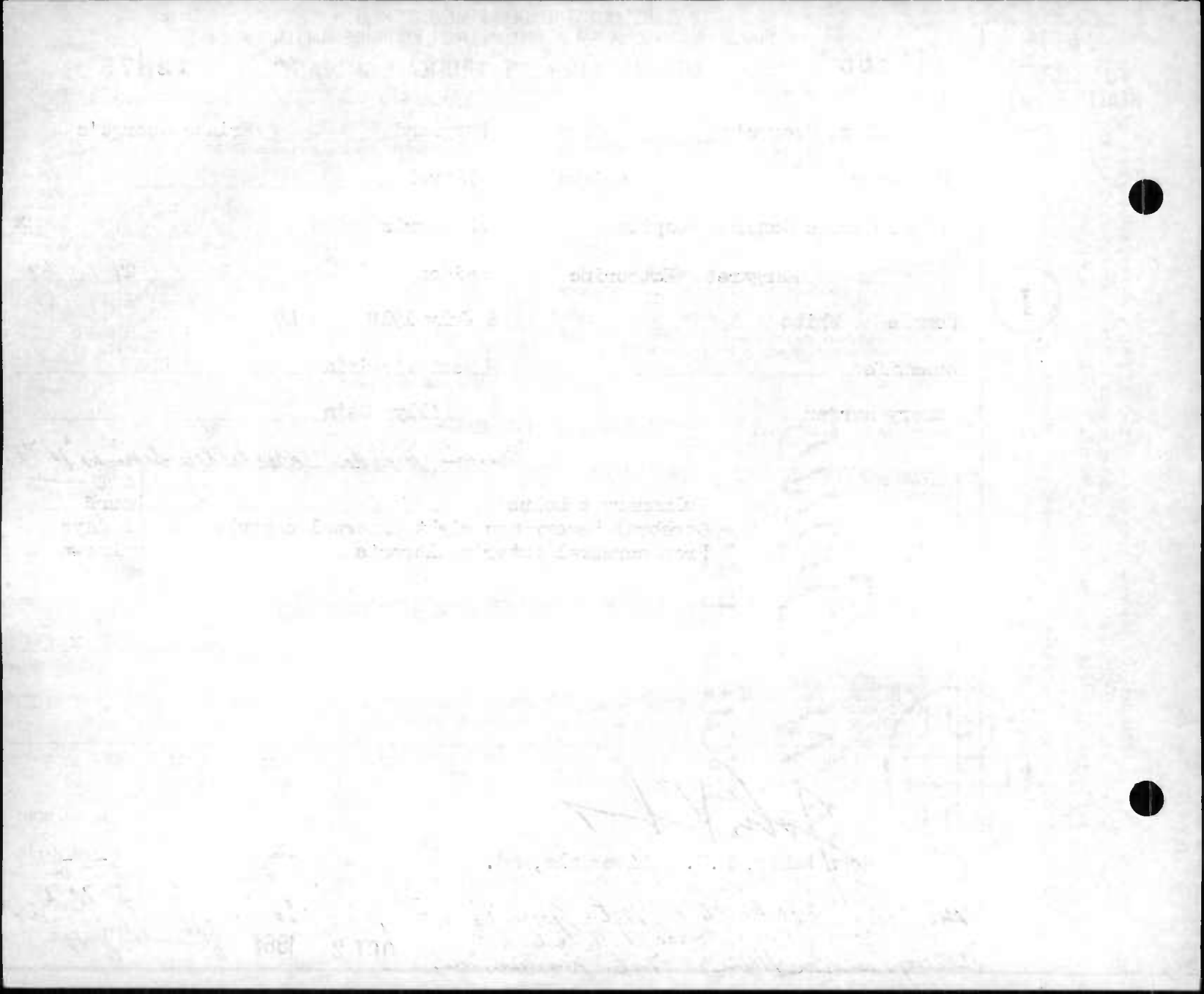
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12866

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12875

|   |                                  |   |  |  |   |   |   |
|---|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  |   | c. LENGTH OF STAY in lb<br><b>4 days</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Laurel</b> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>   |                                  |   |  |  | d. STREET ADDRESS<br><b>12 Morris Drive</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>Katherine</b> Last <b>Maiden</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>27</b> Year <b>19 67</b>   |   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6 July 1918</b>   |  | 9. AGE (In years last birthday)<br><b>49</b> yrs.   | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>27</b>                         | 11. IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                    |   |
| 13. FATHER'S NAME<br><b>Emery Harden</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lilly Cain</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Marvin Maiden Berkeley Springs W. Va.</b> Address  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b><br><b>332 X</b> DUE TO <b>Cerebral hemorrhage right external capsule</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>From cerebral arteriosclerosis</b><br>DUE TO (c) <b>unknown</b>  |                                  |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |  |   |   |   |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |   |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |   |
|   |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   |   |
|   |                                  |   |  | Address (Street, city, town, or county)<br><b>9-28-67</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>10/11/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Int. Zion Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Morgan County, W. Va.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Nalley Funeral Home</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                            |   |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

12867

12876

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Prince George</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md - 161</u><br>d. STREET ADDRESS <u>5621 Hawthorne St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Angelo</u> First <u>Malatesta</u> Middle <u>Malatesta</u> Last<br><b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>24</u> Year <u>1967</u>   |  | <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>12-15-1896</u> <b>9. AGE</b> (In years lost birthday) <u>70</u> yrs.<br><b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Sanman</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Railroad Co</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Italy</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  | <b>13. FATHER'S NAME</b> <u>Anthony Malatesta</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Rachella Falasco</u><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.I</u><br><b>16. SOCIAL SECURITY NO.</b> <u>  </u><br><b>17. INFORMANT</b> <u>Margaret Malatesta, Cheverly, Md -</u> Address <u>  </u>   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u><br>DUE TO (c) <u>Arteriosclerotic heart disease</u> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>8 days</u><br><u>Unknown</u>  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work<br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1963</u> <b>to</b> <u>9-24</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>9-24</u> , 19 <u>67</u> , <b>and that death occurred at</b> <u>9:55 AM</u> , <b>from causes and on the date stated above.</b>   |  |   |  |
| <b>22a. SIGNATURE</b><br><u>John Kehoe</u> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN KEHOE</u>   |  | <b>22b. DATE SIGNED</b> <u>9-24-67</u><br><b>22d. ADDRESS</b> <u>RIVERDALE, MD.</u>   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u><br><b>23b. DATE THEREOF</b> <u>Sept 26, 1967</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft Lincoln Cemetery</u><br><b>23d. LOCATION (City or Town)</b> (County) (State) <u>Colmar Manor Pro Geo Md.</u>  |  | <b>24. FUNERAL DIRECTOR</b> <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u><br><b>25a. REC'D BY REGISTRAR</b> <u>SEP 26 1967</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1945

UNITED STATES DEPARTMENT OF AGRICULTURE

1945

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES", "DEPARTMENT OF AGRICULTURE", and "1945" are visible.]*





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12868.

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12877

|  |                                  |  |  |   |   |
|--|----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b> MARYLAND  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George's</b> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Hills</b> 161  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>  |                                  |  | d. STREET ADDRESS<br><b>3326 Curtis Drive</b>  |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Louise Ruth Mangum</b>   |                                  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>9 27 1967</b>   |   |   |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>1-21-17</b>   |   | 9. AGE (In years last birthday) yrs.<br><b>50</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington D. C.</b>    |   |
| 13. FATHER'S NAME<br><b>Russel Violet</b>  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Mender</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>William W. Mangum</b> Address<br><b>Same As # 2</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>353.3</b> IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Epileptic seizure</b><br>DUE TO<br>(c)   |                                  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Calcific aortic stenosis</b>   |                                  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |  |   |   |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>John Kenoe M.D., Riverdale, Maryland</b>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |  | 22. DATE SIGNED<br><b>9-30-67</b>                                       |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>10/2/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balt. National Cemetery</b>    |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |                                  | 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm Funeral Home</b><br><b>4308 Suitland Road, Suitland, Maryland</b>   |  |   |   |
| 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 6 1967</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>   |  |   |   |

1987

WILLIAM A. HENNING

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

12878

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                           |   |  |  |  |   |   |
|--|---------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Prince George's MARYLAND   |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br>Maryland b. COUNTY<br>Prince George's   |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Beltsville   |                           |   | c. LENGTH OF STAY IN TB<br>18 days   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Greenbelt 16.1 |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>wooded area off Kenilworth Ave.  |                           |   |  | d. STREET ADDRESS<br>1*B Research Road   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Salvatore (SAM) A. Marchesoni   |                           |   |  | 4. DATE OF DEATH<br>Month Day Year<br>9 27 19 67   |  |   |   |
| 5. SEX<br>male   | 6. COLOR OR RACE<br>white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>6-7-32   |  | 9. AGE (In years last birthday)<br>35 yrs.   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>ECONOMIST.  |                           |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. BUREAU OF CENSUS                                   |  | 11. BIRTHPLACE (State or foreign country)<br>NEW YORK  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |
| 13. FATHER'S NAME<br>NICOLA MARCHESONI   |                           |   |  | 14. MOTHER'S MAIDEN NAME<br>JOSEPHINE PILATO   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>YES ROBBAN  |                           | 16. SOCIAL SECURITY NO.<br>080 24 7350  |  | 17. INFORMANT<br>PAULINE B. MARCHESONI   |  | Address<br>SAME AS #2   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Undetermined<br>795.2<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) OUE TO<br>(c) OUE TO   |                           |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br>19   |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> |                           |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>John Kehoe M.D., Riverdale, Maryland   |                           |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |  |   |   |
| 22. DATE SIGNED<br>9-30-67   |                           |   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |                           | 23b. DATE THEREOF<br>SEPT 27 1967   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NATIONAL MILITARY P. & CEMETERY  |  | 23d. LOCATION (City or Town) (County) (State)<br>MURFREESBORO, TENNESSEE                          |   |
| 24. FUNERAL DIRECTOR<br>W.W. CHAMBERS, GO. RIVERDALE, MD   |                           |   |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 2 1967   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach on carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12870

CERTIFICATE OF DEATH

12879

|   |                                  |   |                                      |   |   |   |  |
|---|----------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Geo.</b> MARYLAND   |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Pr. Geo.</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Landover Hills</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>20 yrs.</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Landover Hills</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7106 - Varnum St.</b>  |                                  |   |                                      | d. STREET ADDRESS<br><b>7106 - Varnum St.</b>   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Elizabeth M. Marean</b>   |                                  |   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><b>Sep. 28 19 67</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/31/1874</b> | 9. AGE (In years lost birthday)<br><b>93</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Connecticut</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John J. Power</b>   |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary J. Ward</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                      | 17. INFORMANT<br><b>Mr. Everett J. Marean - above address</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary-Sclerotic Heart Disease with</b><br>DUE TO<br><b>Cardiac Decompensation</b><br>(c) <b>5 yrs</b> |                                  |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |                                      |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/13/65</b> , 19 <b>65</b> , to <b>9/27/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/27/67</b> , 19 <b>67</b> , and that death occurred at <b>2 PM</b> , from causes and on the date stated above.  |                                  |   |                                      |   |   |   |  |
| 22a. SIGNATURE<br><b>James A. O'Keefe</b>   |                                  |   |                                      | 22b. DATE SIGNED<br><b>9/28/1967</b>  |   | 22c. PHYSICIAN'S NAME (Type)<br><b>James A. O'Keefe MD</b>  |  |
| 22d. ADDRESS<br><b>13,000 Georgia Ave</b>   |                                  |   |                                      |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>10/2/1967</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>                          |  |
| 24. FUNERAL DIRECTOR<br><b>Nalley's Funeral Home Inc.</b>   |                                  |   |                                      | 25a. REC'D BY REGISTRAR<br><b>DATE OCT 4 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

John F. Power

John F. Power

John F. Power

John F. Power

John F. Power

John F. Power

John F. Power

John F. Power

(180)

1/2/50

John F. Power

John F. Power

John F. Power

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12880

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>PRINCE GEORGE</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>               |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HYATTSVILLE</u>  |                                  | c. LENGTH OF STAY IN TB<br><u>1 month</u>   |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BETHESDA ROCKVILLE</u>   |                                  | 15-2  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>CARROLL MANOR - 4922 LA SALLE ROAD</u>   |                                  | d. STREET ADDRESS<br><u>1615 E. JEFFERSON STREET</u><br><u>4405 EAST WEST HIGHWAY</u>   |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>VICTORIA</u> Middle <u>V.</u> Last <u>MARIANI</u>  |                                  | 4. DATE OF DEATH<br>Month <u>9</u> - Day <u>12</u> - Year <u>1967</u>   |                                     |
| 5. SEX<br><u>female</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8/6/1900</u> |
| 9. AGE (In years last birthday)<br><u>67</u> yrs.   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOME MAKER</u>   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>PHILADELPHIA, PA.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                     |
| 13. FATHER'S NAME<br><u>Theodore ADAMIANUS</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>PETRONELLA LATKIS</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>578-16-5819A</u>  |                                     |
| 17. INFORMANT<br><u>Elizabeth - Carroll Manor</u>   |                                  | Address   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>DUE TO (b) <u>Recurrent adenocarcinoma of Rectum</u><br>DUE TO (c) <u>(Resected 1962)</u>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>(5 yrs)</u>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Pyelonephritis</u>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>Sept</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 11</u> , 19 <u>67</u> , and that death occurred at <u>10<sup>10</sup> A.M.</u> , from causes and on the date stated above. |                                  |   |                                     |
| 22a. SIGNATURE<br><u>Louis J. Goffredi</u>  |                                  | 22b. DATE SIGNED<br><u>9-12-67</u>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Louis J. Goffredi</u>  |                                  | 22d. ADDRESS<br><u>1801 Eye St. N.W. WASHINGTON, D.C.</u>   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>9-16-1967</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>National Memorial Park</u>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><u>Fairfax Co. Va.</u>   |                                     |
| 24. FUNERAL DIRECTOR<br><u>Joseph Gawler's Sons</u><br><u>5130 Wisc. Ave. N.W. Wash. D.C. Inc.</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>SEP 18 1967</u>   |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |                                  |   |                                     |



UNITED STATES DEPARTMENT OF AGRICULTURE

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be a report or form with various sections and headings.]*



RECEIVED  
U. S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.  
JAN 10 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |   |  |                                     |   |   |
|--|---|--|-------------------------------------|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |   |  |                                     |   |   |
| 12872  |   | CERTIFICATE OF DEATH   |                                     | 12881   |   |
| 1. PLACE OF DEATH<br>o. COUNTY <u>PRINCE GEORGES</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>                      |                                     |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FORESTVILLE</u>   |   | c. LENGTH OF STAY IN 1b<br><u>1 mo. + 21 da</u>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TEMPLE HILLS</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>REGENT NURSING HOME</u>   |   | d. STREET ADDRESS<br><u>5603 HUNTLAND RD.</u>  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>MARINSHAW, ELIZABETH B.</u>  |   | 4. DATE OF DEATH<br>Month <u>SEPT.</u> Day <u>21</u> Year <u>1967</u>  |                                     |   |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-7-1882</u> | 9. AGE (In years last birthday)<br><u>85</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>14</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>  |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><u>HUNGARY</u>                                   |   |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>   |                                     |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>unknown</u>   |   | 16. SOCIAL SECURITY NO.<br><u>—</u>  |                                     | 17. INFORMANT<br><u>Stephen A. Marinshaw</u> Address<br><u>Same As # 2</u>                              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause }<br>(b) <u>Hypertensive Cardiovascular Disease</u> DUE TO<br>(c) <u>—</u> |   |  |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 1/2 mo</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)                 | (County)  | (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>67</u> , to <u>9/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/21</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> PM, from causes and on the date stated above.   |   |  |                                     |   |   |
| 22a. SIGNATURE<br><u>Frank J. Fedor</u>  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                   |                                     | 22b. DATE SIGNED<br><u>9/21/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>FRANK J. FEDOR MD</u>   |   | 22d. ADDRESS<br><u>4201 CATHEDRAL AVE N.W.</u>   |                                     |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>9/25/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Resurrection Cemetery</u>   |                                     | 23d. LOCATION (City or Town) (County) (State)<br><u>Clinton, Prince Georges Md.</u>                     |   |
| 24. FUNERAL DIRECTOR<br><u>Robert E. Wilhelm Funeral Home</u><br><u>4308 Suitland Road, Suitland, Maryland</u>   |   | 25a. REC'D BY REGISTRAR<br><u>SEP 25 1967</u>  |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

RECEIVED  
JAN 10 1967  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

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RECEIVED  
JAN 10 1967  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

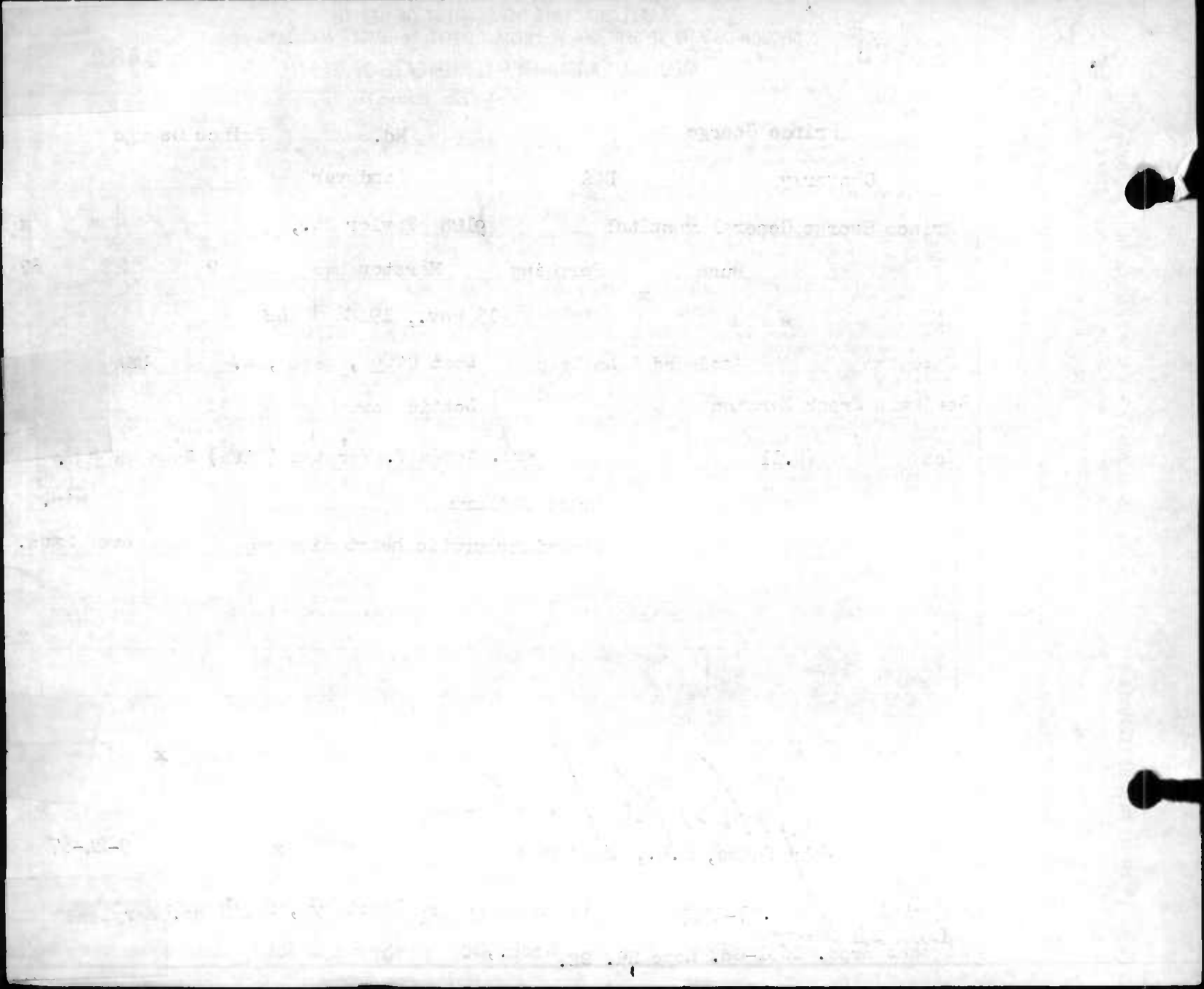
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12873

12882

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b> b. COUNTY<br><b>Prince George</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>   |  | d. STREET ADDRESS<br><b>9108 Taylor St.,</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Bush</b> Middle <b>Pershing</b> Last <b>Marston</b>   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>23</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>13 Nov., 1918</b>  |
| 9. AGE (In years last birthday)<br><b>48</b> yrs.   |  | 10. IF UNDER 1 Year<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Woodward &amp; Lothrop</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Lost City, West, Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Benjamin Frank Marston</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lottie Bowman</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW.11</b>   |  | 16. SOCIAL SECURITY NO.<br><b>WW.11</b>  |   |
| 17. INFORMANT<br><b>Mrs. Wanda V. Marston (Wife) Same as # 2.</b>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO (b) <b>Arteriosclerotic heart disease</b><br>DUE TO (c) <b>over 2mos.</b>   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Min.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe, M.D., Riverdale</b>  |  | 22. DATE SIGNED<br><b>9-24-67</b>  |   |
| EXAMINER'S NAME (Type)  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Sept. 27, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National Cemetery, Suitland, Maryland</b>  | 23d. LOCATION (City or Town) (County) (State)   |
| 24. FUNERAL DIRECTOR<br><b>Simmons Bros. 1661-Gd. Hope Rd. SE, Wash., DC</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 26 1967</b>  |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



12874

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12883

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince George's</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>  |                                     | d. STREET ADDRESS<br><b>5202 Paducah Street</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Harry George Mc Kiver</b>   |                                     | 4. DATE OF DEATH<br>Month Day Year<br><b>9 22 19 67</b>  |   |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>3-4-94</b>   |
| 9. AGE (In years lost birthday) yrs.<br><b>73</b>  |                                     | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Gov. Printing Office</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ohio</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Retired Gov. Printing Office</b>   |                                     | 14. MOTHER'S MAIDEN NAME   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>577-24-1137</b>  |   |
| 17. INFORMANT<br><b>Cecelia McKiver #2 above</b>   |                                     | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart Failure</b><br><b>4200</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO<br>(c)  |                                     | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                     |  |   |
| ACTUAL SIGNATURE<br><b>John Kehoe M.D., Riverdale, Maryland</b>  |                                     | 22. DATE SIGNED<br><b>9-23-67</b>  |   |
| EXAMINER'S NAME (Type)<br><b>John Kehoe M.D., Riverdale, Maryland</b>  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>9/25/67</b> | 23c. NAME OF CEMETERY OR CREMATOR<br><b>Fort Lincoln</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Bladensburg, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Jas. T. Ryan, Inc.</b>  |                                     | 25a. REC'D BY REGISTRAR<br><b>SEP 26 1967</b>  |   |
| ADDRESS<br><b>317 Pa. Ave., SEDC</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>   |   |

THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C.

MEMORANDUM FOR THE CHIEF OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>   |  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>                                       |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greenbelt Convalescent Center</b>   |  |  |  |  | d. STREET ADDRESS <b>2842 Meadow Lane</b>  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Minnie V. McLaughlin</b>   |  |  |  |  | 4. DATE OF DEATH <b>Sept. 30 19 67</b>   |   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Aug. 15, 1891</b>                                 |  | 9. AGE (In years last birthday) <b>76</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 13. FATHER'S NAME <b>Joseph Fitzgerald</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Fellon</b>  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>--</b>  |  | 17. INFORMANT <b>Mrs. Helen M. Cherry</b>  |  | Address <b>Same As #2</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GEN. ARTERIOSCLEROSIS</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBROVASCULAR ACCIDENT</b> |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b><br><b>UNKNOWN</b>                             |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)           |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8-16</b> , 19 <b>67</b> , to <b>9-30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-30</b> , 19 <b>67</b> , and that death occurred at <b>1:20</b> PM, from the causes and on the date stated above.   |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE <b>Carl J. Houmann</b> M.D.  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |   | 22b. DATE SIGNED <b>9-30-67</b>                    |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Carl J. Houmann, M. D.</b>  |  |  |  |  | 22d. ADDRESS <b>4400 Queensbury Rd., Riverdale, Md</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>10/3/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR <b>J. Wm/ Lees Sons, Washington, D. C.</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>OCT 3 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b> |  |  |

United States

of

George Washington University

Washington, D.C.

April 15, 1954

Dear Sir:

Very truly yours,

John H. Garvey

Director

George Washington University

Washington, D.C.

Enclosed for you are

three copies of a

report on the

work of the

Committee on

the Study of

the History of

the American

People

in the

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12876

Item #3 Film #G393 10/2/67 ph

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |   |                                      |  |   |   |  |
|--|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>  |                                  |   |                                      | c. LENGTH OF STAY IN 1b  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4503 Emerson St.</b>   |                                  |   |                                      | d. STREET ADDRESS <b>Bowie Rt. 3</b>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ulys</b> Middle <b>Burns</b> Last <b>Meals</b>   |                                  |   |                                      | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>20</b> Year <b>1967</b>  |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-19-1896</b> | 9. AGE (In years last birthday) yrs. <b>71</b>   | IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>20</b> |   | IF UNDER 24 HRS.<br>Hours <b>19</b> Min. <b>67</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Guard</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U S G</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Alabama</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |
| 13. FATHER'S NAME<br><b>James H Meals</b>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Eula Gordon</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>yes WW I</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>418 05 8756</b>   |                                      | 17. INFORMANT<br><b>Charles D Meals</b> Address <b>Hyattsville, Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b><br><b>976X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO<br>(c) _____   |                                  |   |                                      |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |                                      |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Shot self with .410 gauge shot gun.</b>                  |                                      |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>10:45am</b> p.m. <b>9-20-1967</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>4503 Emerson St., Hyattsville, Md.</b>  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                      |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe, M.D.</b>  |                                  | 22. DATE SIGNED<br><b>9-20-67</b>   |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Transportation</b>   |                                  | 23b. DATE THEREOF<br><b>Sept 21, 1967</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Athens</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Alabama</b>                                   |  |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>   |                                  |   |                                      | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY

TO THE HONORABLE CHAIRMAN OF THE BOARD OF TRUSTEES  
OF THE UNIVERSITY OF CHICAGO

FROM  
THE DEPARTMENT OF CHEMISTRY  
CHICAGO, ILLINOIS

REPORT  
ON THE PROGRESS OF THE  
RESEARCHES OF THE  
DEPARTMENT OF CHEMISTRY  
DURING THE YEAR 1911

BY  
THE DEPARTMENT OF CHEMISTRY

CHICAGO, ILLINOIS

1912

CHICAGO, ILLINOIS

CHICAGO, ILLINOIS

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12877

CERTIFICATE OF DEATH

12886

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>16-1</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George's</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>   |   | d. STREET ADDRESS<br><b>2506 Lake Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Marshall</b><br>Middle<br><b>M.</b><br>Last<br><b>Miller</b>   |   | 4. DATE OF DEATH<br>Month<br><b>Sept.</b><br>Day<br><b>19</b><br>Year<br><b>19 67</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>8/6/88</b>                                      |
| 9. AGE (In years last birthday)<br><b>79</b> yrs.   |   | 10. IF UNDER 1 YEAR<br>Months<br><b>16</b><br>Days<br><b>1</b>   | 11. IF UNDER 24 HRS.<br>Hours<br><b>1</b><br>Min.                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Salesman</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Oil Business</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Colorado</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Lyman Joseph Miller</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Miriam Bowman</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1918-1919</b>   |   | 16. SOCIAL SECURITY NO.<br><b>577-09-5300A</b>   |  |
| 17. INFORMANT<br><b>Mrs. Ethel Catherine Miller</b>   |   | Address <b>See Item #2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>4201</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b> |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour: a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 1962, to <b>9/19, 1967</b> that (I) (we) last saw the deceased alive on <b>9/18, 1967</b> and that death occurred at <b>12:41</b> M, from causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE<br><b>F.E. Musser</b>  |   | 22b. DATE SIGNED<br><b>9/19/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>F.E. Musser</b>  |   | 22d. ADDRESS<br><b>4410 74 Ave</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE THEREOF<br><b>9-22-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat'l. Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 21 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |  |

1988

REPORT OF

Prince George's

Marshall

on 10/15/88

Marshall

3000 Lake Avenue

Prince George's General Hospital

Miller, J. M. 10/15/88

Marshall

10/15/88

White

Active, 10/15/88, 10/15/88, 10/15/88

10/15/88

10/15/88

10/15/88, 10/15/88, 10/15/88, 10/15/88

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Pathologic fracture/  
Med. Exam. notified/  
release, 9/7/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12878

12887

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince Georges</b>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>  |   |
| c. LENGTH OF STAY in 1b<br><b>35 days</b>  |  | d. STREET ADDRESS<br><b>40005 Buchanon Street</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Viola</b> Middle <b>F.</b> Last <b>Montagne</b>  |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>7</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/20/01</b>                                       |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>16</b> Days <b>1</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>PA.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>DENNIS FITZPATRICK</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY K. DELANEY</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>217-52-5776</b>   |   |
| 17. INFORMANT<br><b>PHILLIP J. NONTAGNE</b>  |  | Address<br><b>Husband Same #2</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatous</b><br><b>170X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>adenomocarcinoma breast</b> (c) <b>8</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>arteriosclerotic heart disease</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) <b>physician</b> attended the deceased from <b>Nov.</b> , 19 <b>65</b> , to <b>Sept. 7</b> , 1967, that (I) <b>last</b> saw the deceased alive on <b>Sept. 7</b> , 1967, and that death occurred at <b>3:15 PM</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Don B. Cameron</b> M.D.   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             | 22b. DATE SIGNED<br><b>9-7-67</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Don B. Cameron, M. D.</b>   |  | 22d. ADDRESS<br><b>3503 Perry St., Mt. Rainier, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>8-9-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>WASHINGTON, D. C.</b> |
| 24. FUNERAL DIRECTOR<br><b>GASCH'S</b>   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 11 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                        |



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12873

12888

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>  |                               | c. LENGTH OF STAY IN 1b <b>DOA</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>Joseph Patrick Morano</b>   |                               | 4. DATE OF DEATH <b>9 10 19 67</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1-8-1942</b>                 |
| 9. AGE (In years lost birthday) <b>25</b> yrs.   |                               | 10. UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>67</b>   | 11. UNDER 24 HRS. Hours <b>19</b> Min. <b>67</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packing plant</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Safeway store</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  |
| 13. FATHER'S NAME <b>Frank A Morano</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Bernice L Brosky</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes 1962 to 1964</b>  |                               | 16. SOCIAL SECURITY NO. <b>220 38 4415</b>   |  |
| 17. INFORMANT <b>Amelia M Morano</b>   |                               | Address <b>College Park, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left hemothorax</b><br><b>984X</b><br>DUE TO <b>Perforating gun shot wound of chest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                               |  | INTERVAL BETWEEN ONSET AND DEATH                 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by policeman during altercation</b>                 |  |
| 20c. TIME OF INJURY Month, Day, Year <b>1:46am p.m. 9-10- 19 67</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> In front of <b>9729 51st. Pl., Prince Geo. Co.</b>     |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>    |                               |  |  |
| ACTUAL SIGNATURE <b>John Kehoe, M.D.</b> M.D.  |                               | 22. DATE SIGNED <b>9-11-67</b>   |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b> Riverdale, Md.  |                               | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>Sept 14, 1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>  |  |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> Hyattsville, Md.   |                               | 25a. REC'D BY REGISTRAR <b>SEP 14 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>   |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12880

12889

|  |                               |   |  |  |  |  |   |
|--|-------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                               |   | c. LENGTH OF STAY IN 1b <b>DOA</b>   |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> <b>16.1</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>   |                               |   |  | d. STREET ADDRESS <b>4906 Olympia Avenue</b>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Austin</b> Middle <b>T.</b> Last <b>Morris Jr.</b>   |                               |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>15</b> Year <b>19 67</b>   |  |  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>4 April 1903</b>   |  | 9. AGE (In years lost birthday) <b>64</b> yrs.                         | 10. IF UNDER 1 YEAR<br>Months <b>15</b> Days <b>19</b> Hours <b>67</b> Min.                                    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>   |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>U S P O</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>New York</b>              |  | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>                           |
| 13. FATHER'S NAME <b>Austin Morris</b>   |                               |   |  | 14. MOTHER'S MAIDEN NAME <b>Margaret Owens</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W W I</b>   |                               |   | 16. SOCIAL SECURITY NO. <b>579 280 863</b>   |  | 17. INFORMANT <b>Evelyn L Morris</b> Address <b>Beltsville, Md.</b>    |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b> DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____<br>(c) _____   |                               |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 2 yrs</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                               |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |  |  |  |  |   |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.  |                               |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22. DATE SIGNED <b>9-15-67</b>   |   |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>  |                               |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               |   | 23b. DATE THEREOF <b>Sept 19, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATOR <b>Baltimore National</b>            |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>  |                               |   | 25a. REC'D BY REGISTRAR <b>SEP 20 1967</b> DATE  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                        |  |   |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

12890

12881

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                              |   |   |  |   |
|---|------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Pr. Geo.</u> MARYLAND   |                              |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo.</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CHWINTON</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>4 HOURS</u>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CHWINTON</u>   |  | <u>16.1</u>   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SOUTHERN MARYLAND HOSP. CENTER</u>   |                              |   | d. STREET ADDRESS<br><u>7847 Horseshoe Dr.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>DAISY</u> Middle <u>B.</u> Last <u>MYERS</u>  |                              |   | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>11</u> Year <u>1967</u>   |  |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4/28/84</u>  |  | 9. AGE (In years last birthday)<br><u>83</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Page Co. Va.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |
| 13. FATHER'S NAME<br><u>Benjamin Franklin Strickler</u>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><u>Bernice Catherine Strickler</u>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                              | 16. SOCIAL SECURITY NO. (If yes give war or dates of service)   | 17. INFORMANT<br><u>Louise Gilbert</u> Address  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO<br>(b) <u>MASSIVE CEREBROVASCULAR HEMORRHAGE</u><br>DUE TO<br>(c) <u>HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE</u><br>20 YRS.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>None</u> |                              |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 MIN.</u>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>None</u>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>None</u>   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br><u>None</u>   |                              | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><u>None</u>  |  | 20f. (City or town) (County) (State)<br><u>None</u>   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1956</u> to <u>present</u> and that (I) <u>was</u> saw the deceased alive on <u>SEPT 11 1967</u> , and that death occurred at <u>9:05 PM</u> from causes and on the date stated above.  |                              |   |   |  |   |
| 22a. SIGNATURE<br><u>Arthur Shaver</u>  |                              | 22b. DATE SIGNED<br><u>9/11/67</u>  |   | 22c. PHYSICIAN'S NAME (Type)<br><u>ARTHUR SHAVER JR. MD.</u> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE THEREOF<br><u>9-14-1867</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Fort Lincoln Cemetery</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Bladensburg Maryland</u>                      |
| 24. FUNERAL DIRECTOR<br><u>Robert E. Wilhelm</u><br><u>4308 Suitland Road Suitland Maryland</u>   |                              |   | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 13 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

12882

12891

|  |                              |   |   |  |   |   |  |
|--|------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>PRINCE GEORGES</b> MARYLAND  |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MD.</b> b. COUNTY <b>Pr. Geo.</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CHINTON</b>   |                              |   |   | c. LENGTH OF STAY IN lb<br><b>26 days</b>  |   |   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>UPPER MARLBORO</b>  |                              |   |   | d. STREET ADDRESS<br><b>9503 NOTTINGHAM DR.</b>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>PINEVIEW GARDENS HEALTH CARE CENTER</b>   |                              |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>FORD</b> Last <b>NEWSON</b>  |                              |   |   | 4. DATE OF DEATH<br>Month <b>SEPT.</b> Day <b>6</b> Year <b>1967</b>   |   |   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 30 1883</b> |  | 9. AGE (In years last birthday)<br><b>84</b> yrs. | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MEAT CUTTER</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>ST. MARY'S COUNTY MD</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John Nelson</b>  |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Guy</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                              | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Dorothy Sullivan</b> Address <b>9503 Nottingham Dr</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION, ACUTE</b><br><b>4201</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (c) <b>ARTERIOSCLEROTIC CV disease with congestive failure, healed hypertension</b> |                              |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 MIN</b><br><b>1 HOUR</b><br><b>5 YRS.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>GENERALIZED CARCINOMATOSIS - CA STOMACH</b>  |                              |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |   |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>None</b>  |                              | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work<br><b>None</b>                         |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><b>None</b>  |   | 20f. (City or town) (County) (State)<br><b>None</b>   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> , 1967, to <b>Present</b> , that (I) (we) last saw the deceased alive on <b>Sept 6</b> , 1967, and that death occurred at <b>5:42 PM</b> , from causes and on the date stated above.  |                              |   |   |  |   |   |  |
| 22a. SIGNATURE<br><b>Arthur Shaver Jr.</b> M.D.  |                              |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        |   | 22b. DATE SIGNED<br><b>9/6/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ARTHUR SHAVER JR. MD</b>  |                              |   |   | 22d. ADDRESS<br><b>8808 BRANCH AVE. CHINTON, MD.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>9-9-1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm</b> Address <b>4308 Suitland Rd Suitland Maryland</b>   |                              |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 11 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12883

12892

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PRINCE GEORGES</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TEMPLE HILLS</b> 16.1  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGES GENERAL HOSPITAL</b>  |  | d. STREET ADDRESS <b>5218 JANICE LANE</b>  |   |
| 3. NAME OF DECEASED (Type or print) <b>CHARLES R. NIFFENEGGER</b> First Middle Last  |  | 4. DATE OF DEATH <b>SEPT 29 1967</b> Month Day Year  |   |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>DEC. 21, 1922</b>   |
| 9. AGE (In years last birthday) <b>44</b> yrs.   |  | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMIST</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>US GOVERNMENT</b>   | 11. BIRTHPLACE (County & State, or foreign country) <b>MICHIGAN</b>                 |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 13. FATHER'S NAME <b>CHRIST NIFFENEGGER</b>  |   |
| 14. MOTHER'S MAIDEN NAME <b>EMLY A. BLANK</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>ALICE K. NIFFENEGGER</b> Address <b>SAME AS# 2</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c) |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b><br><b>YEARS</b>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 to <b>9-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-29</b> , 19 <b>67</b> , and that death occurred at <b>6P</b> M, from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE <b>Herbert Wisotsky</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>HERBERT WISOTSKY</b>   |  | 22d. ADDRESS <b>101 ANDREY C.A. ex on this ind.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE THEREOF <b>10/3/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGES, Md.</b>  |
| 24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Road, Suitland, Maryland</b>   |  | 25a. REC'D BY REGISTRAR <b>OCT 6 1967</b> DATE   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

12884

**CERTIFICATE OF DEATH**

12893

|  |                              |   |                                     |
|--|------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>          |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bowie, Maryland</b>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bowie Md.</b>  |                                     |
| c. LENGTH OF STAY IN 1b  |                              | d. STREET ADDRESS<br><b>12619 MEMORY LA.</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>12619 MEMORY LA.</b>  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Joseph</b> Last <b>Omelina</b>  |                              | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>16</b> Year <b>1967</b>   |                                     |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-9-1909</b> |
| 9. AGE (In years last birthday)<br><b>58</b> yrs.  |                              | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>8</b> Hours <b>16</b> Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PRINTER</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T.</b>   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>MILWAUKEE, Wisc.</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                     |
| 13. FATHER'S NAME<br><b>UNK.</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>? BOBYK</b>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Y-S</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>WW II</b>   |                                     |
| 17. INFORMANT<br><b>ELEANOR G. OMELINA #2</b>  |                              | Address   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br><b>150X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>carcinoma of the esophagus.</b><br>DUE TO<br>(c) |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b><br><b>2 yrs.</b>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (the physician) attended the deceased from <b>Nov.</b> , 19 <b>65</b> , to <b>Sept.</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Sept. 9</b> , 19 <b>67</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.                                       |                              |   |                                     |
| 22a. SIGNATURE<br><b>John Cosma M.D.</b>   |                              | 22b. DATE SIGNED<br><b>9-16-67</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John Cosma, M.D.</b>  |                              | 22d. ADDRESS<br><b>3233 Superior La., B--3, Bowie, Md.</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                              | 23b. DATE THEREOF<br><b>9-28-67</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>WISCONSIN MEMORIAL CEMETERY</b>   |                              | 23d. LOCATION (City, town or county) (State)<br><b>BROOKFIELD Wisc.</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>John M. Lofgren</b>   |                              | 25a. REC'D BY REGISTRAR<br><b>SEP 18 1967</b>   |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>John M. Lofgren</b>   |                              | 25c. REGISTRAR'S NAME<br><b>John M. Lofgren</b>   |                                     |

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THE STATE OF WISCONSIN  
COUNTY OF MILWAUKEE  
JANUARY 1908

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this 28th day of January, 1908.  
Notary Public for the State of Wisconsin  
F. J. [Signature]

Witness my hand and seal of office this 28th day of January, 1908.  
Notary Public for the State of Wisconsin  
F. J. [Signature]

Subscribed and sworn to before me this 28th day of January, 1908.  
Notary Public for the State of Wisconsin  
F. J. [Signature]

Witness my hand and seal of office this 28th day of January, 1908.  
Notary Public for the State of Wisconsin  
F. J. [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12885

Item #3 Film #G393 10/13/67 ph

CERTIFICATE OF DEATH

12894

|   |                        |  |                                    |
|---|------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND   |                        | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE District of Columbia b. COUNTY                         |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville  |                        | c. LENGTH OF STAY IN 1b Two days   |                                    |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington   |                        | 473  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.  |                        | d. STREET ADDRESS 3636 - 16th St., N.W.  |                                    |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                        |  |                                    |
| 3. NAME OF DECEASED (Type or print) Elizabeth First Middle Last A. V. O'Reilly  |                        | 4. DATE OF DEATH September 28 19 67  |                                    |
| 5. SEX Female   | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 25, 1890 77 |
| 9. AGE (In years last birthday) 77 yrs.   |                        | IF UNDER 1 YEAR Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical  |                        | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country) Bethlehem, Pennsylvania   |                        | 12. CITIZEN OF WHAT COUNTRY? United States   |                                    |
| 13. FATHER'S NAME Thomas O'Reilly   |                        | 14. MOTHER'S MAIDEN NAME Mary Quinn  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown   |                        | 16. SOCIAL SECURITY NO. 578-64-9233  |                                    |
| 17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland  |                        |  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4200 Coronary heart failure<br>DUE TO (b) Wilson's disease<br>DUE TO (c) 7 years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                        | INTERVAL BETWEEN ONSET AND DEATH 2 days  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from July 19 56 to 27 Sept. 19 67 that (I) (we) last saw the deceased alive on 27 Sept. 19 67 and that death occurred at 12 A.M. from causes and on the date stated above.   |                        |  |                                    |
| 22a. SIGNATURE Robert C. Haile M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |                        | 22b. DATE SIGNED 4-28-67   |                                    |
| 22c. PHYSICIAN'S NAME (Type) ROBERT C. HAILE  |                        | 22d. ADDRESS 35 NEW YORK AVENUE, N. W. WASH. D.C.  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  |                        | 23b. DATE THEREOF 9-30-67  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY   |                        | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D. C.  |                                    |
| 24. FUNERAL DIRECTOR Francis J. Collins ADDRESS WASH. D.C. 3821 14TH. ST. N.W.  |                        | 25a. REC'D BY REGISTRAR OCT 3 1967   |                                    |
|   |                        | 25b. REGISTRAR'S SIGNATURE Charles Judge   |                                    |





FOR STATE  
HEALTH DEPT.

1  
12886  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12835

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |  | c. LENGTH OF STAY IN 1b <b>DOA</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>  |  | d. STREET ADDRESS <b>5100 Lubbock St.</b>   |  |
| 3. NAME OF DECEASED (Type or print) <b>Henry Clifford Orfield</b>   |  | 4. DATE OF DEATH <b>9 18 19 67</b>  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>9-24-1911</b>  |
| 9. AGE (In years last birthday) <b>55</b> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>   |  |
| 11. BIRTHPLACE (state or foreign country) <b>Tennessee</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>? Orfield</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Cora Music</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT <b>Gary L. Orfield</b>  |  | Address <b>Same As # 2</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO <b>Hypertensive cardio vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____   |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 6 mo.</b>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.   |  | 22. DATE SIGNED <b>9-19-67</b>  |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>9/21/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State) <b>Suitland Prince Georges Md.</b>               |
| 24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR <b>SEP 25 1967</b>  |  |
| 4308 Suitland Road, Suitland, Maryland  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

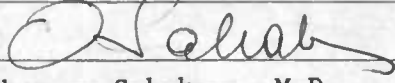


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12887

**CERTIFICATE OF DEATH**

12896

|  |                                  |   |  |  |  |   |   |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>15 days</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brentwood</b>   |  |   | 16-1  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>4009 Utahave</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Agnes F Parsons</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>September 2, 1967</b>   |  |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/3/94</b>  | 9. AGE (In years last birthday)<br><b>73</b> YRS.  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Federal employee U S Government</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>St Mary's County Md.</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |
| 13. FATHER'S NAME<br><b>William F. Twilley</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Harrett Thomas</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>215 36 5245</b>  |  | 17. INFORMANT<br><b>Milton L. Parsons</b> Address <b>Lanham, Md.</b>               |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolism right lung</b><br><b>4201</b><br>DUE TO <b>Myocardial infarction, massive</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Coronary occlusion, left anterior descending</b><br>DUE TO<br>(c) <b>Coronary arteriosclerotic Heart Disease</b> |                                  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , to <b>Sept. 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept. 2, 1967</b> , and that death occurred <b>10:50A</b> M, from causes on and on the date stated above.  |                                  |   |  |  |  |   |   |
| 22a. SIGNATURE<br>  |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                    |  | 22b. DATE SIGNED<br><b>9/2/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M.D.</b>   |                                  |   |  | 22d. ADDRESS<br><b>6001 Landover Road, Cheverly, Md.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Sept 5, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Pro Geo Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons Hyattsville, Md.</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 8 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |   |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Office of the Surgeon General  
Department of Health, Education and Welfare  
Washington, D.C. 20540

STATEMENT OF FACTS

Re: [illegible]

[illegible]

12 days

4000 [illegible]

United States General Hospital

September 1, 1967

Personnel

Admission

12

01/1/67

White

Female

Admission to hospital for [illegible]

of [illegible]

Admission to [illegible]

12:00

Admission to [illegible]

12:00

Primary: ocular [illegible]  
Secondary: [illegible]  
Tertiary: [illegible]

Primary: [illegible]

12:00 - 12:30

12:00 - 12:30

01/1/67

0001 [illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please maye carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12888

CERTIFICATE OF DEATH

12897

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b><br>c. LENGTH OF STAY IN lb<br><b>2 mos.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>CARROLL MANOR</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Hyattsville, Md.</b><br>b. COUNTY<br><b>Pr. Geo.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b><br>d. STREET ADDRESS<br><b>5001 - Eastern Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Brother Eugene S.J. Paulus</b><br>First Middle Last<br>4. DATE OF DEATH<br><b>9 19 1967</b><br>Month Day Year  |  | 5. SEX<br><b>M.</b><br>6. COLOR OR RACE<br><b>W.</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH<br><b>Feb. 4, 1887</b><br>9. AGE (In years last birthday)<br><b>80 yrs.</b><br>IF UNDER 1 YEAR<br>Months Days Hours Min.<br>IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>High School + College Teacher</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br><b>Religious Brother</b><br>11. BIRTHPLACE (County & State, or foreign country)<br><b>Detroit, Michigan</b><br>12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Charles Paulus</b><br>14. MOTHER'S MAIDEN NAME<br><b>Margaret Manigold</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, No, or unknown) <input checked="" type="checkbox"/><br>16. SOCIAL SECURITY NO.<br><b>287-34-5714</b><br>17. INFORMANT<br><b>Sister Dolores</b><br>Address<br><b>4422 LADALLE RD. CARROLL MANOR.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4200 IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease (cong. h. f.)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis, general</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Carcinoma prostate</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Years</b><br><b>Years</b>   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 1955, to <b>Sept 19</b> , 1967, that (I) (we) last saw the deceased alive on <b>Sept 19</b> , 1967, and that death occurred at <b>9:30 p.m.</b> from causes and on the date stated above.   |  |  |  |
| 22a. SIGNATURE<br><b>John F. Brennan Jr.</b><br>22c. PHYSICIAN'S NAME (Type)   |  | 22b. DATE SIGNED<br><b>Sept 19, 1967</b><br>22d. ADDRESS<br><b>M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/23/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oblate Novitiate Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Childs, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Valley's Funeral Home Inc.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 25 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION

STATE OF TEXAS

1900

County of \_\_\_\_\_

No. \_\_\_\_\_

State of Texas - 1900

For the year ending \_\_\_\_\_  
Total \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |  |   |  |  |  |   |  |   |  |
|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                  |  |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |                                  |  |   |  |  |  |   |  |   |  |
| 12888   |  |                                  |  |   |  |  |  |   |  |   |  |
| 12898   |  |                                  |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>D.C.</b> b. COUNTY              |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (rural)</b>   |  |                                  |  | c. LENGTH OF STAY IN 1b<br><b>70 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>                                |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Glenn Dale Hospital</b>  |  |                                  |  |   |  | d. STREET ADDRESS<br><b>1502 Potomac Ave., S.E.</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rose</b> Middle <b>L.</b> Last <b>Payne</b>   |  |                                  |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>25</b> Year <b>19 67</b>   |  |   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12/24/1869</b>  |  | 9. AGE (In years last birthday)<br><b>97</b> yrs. |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |                                  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Decedent</b> Address   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Left cerebrovascular accident</b><br>DUE TO<br>(c) <b>Generalized arteriosclerosis</b> |  |                                  |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>3 mo.</b><br><b>unknown</b>               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerotic heart disease and chronic brain syndrome</b>  |  |                                  |  |   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)              |  |   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/17</b> , 1967, to <b>9/25</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/25</b> , 19 <b>67</b> , and that death occurred at <b>7:00PM</b> , from causes and on the date stated above.                  |  |                                  |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Moe Weiss</b>  |  |                                  |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>9-25-67</b>                |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Moe Weiss, M.D.</b>  |  |                                  |  |   |  | 22d. ADDRESS<br><b>Glenn Dale Hospital<br/>Glenn Dale, Maryland</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION (City or Town) (County) (State)     |  |   |  |
|   |  |                                  |  | <b>SEPT. 30-17 HARMONY MEMORIAL</b>   |  |  |  | <b>7601-SHERIFF LANDOUR MD</b>                    |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>James T. Sutton</b>  |  |                                  |  |   |  | ADDRESS<br><b>2718-12th N.E.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 28 1967</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

234

Journal of

7 days

Glenn (1994)

• • • • • 11/11/2019 09:28

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**Figure 1**

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2001/2/28

1997

7115

9-38-67

ONE YEAR, 1914-1915

2012-2013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |                              |   |                                   |
|--|------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PG. Riverdale. MARYLAND</b>   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md. PG.</b>   |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale.</b>  |                              | c. LENGTH OF STAY IN 1b<br><b>2Days</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Eugene Leland Hospital</b>  |                              | e. STREET ADDRESS<br><b>8616 57th Ave,</b>  |                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Gustey Pickett</b>   |                              | 4. DATE OF DEATH<br>Month Day Year<br><b>9 7- 19 67</b>   |                                   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                 | 8. DATE OF BIRTH<br><b>7-1-92</b> |
| 9. AGE (In years lost birthday)<br><b>75</b> yrs.  |                              | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Md.</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                   |
| 13. FATHER'S NAME<br><b>Ulysses. Pickett</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Lomen, Ester* Esther.</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                              | 16. SOCIAL SECURITY NO.<br><b>217 05 5246</b>   |                                   |
| 17. INFORMANT<br><b>Eugene Leland Hospital, 4408 Queensbury Rd,</b>  |                              | Address   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ac Cardio respiration failure</b><br>DUE TO <b>1621</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic bronchitis</b><br>DUE TO (c) <b>Diabetes Mellitus</b> |                              | INTERVAL BETWEEN ONSET AND DEATH  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bronchitis</b><br>(b) <b>Diabetes Mellitus</b><br>(c) <b>Cardiovascular disease</b>   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept 6, 1967</b> , to <b>Sept 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 6, 1967</b> , and that death occurred at <b>Sept 9, 1967</b> M, from causes and on the date stated above.  |                              | 22a. SIGNATURE<br><b>W. L. Etienne</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>W. L. Etienne</b>   |                              | 22d. ADDRESS<br><b>Call OK</b>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>Sept 11, 1967</b>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Ridge Cemetery</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodbine Carroll Md.</b>  |                                   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |                              | 25a. REC'D BY REGISTRAR<br><b>SEP 11 1967</b>   |                                   |
| ADDRESS<br><b>Hyattsville, Md.</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                   |

STATEMENT OF SERVICE

1. Name: [Name]  
2. Service Number: [Service Number]  
3. Grade: [Grade]  
4. Branch: [Branch]  
5. Component: [Component]  
6. Station: [Station]  
7. Date: [Date]  
8. Signature: [Signature]  
9. Title: [Title]  
10. Remarks: [Remarks]

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12900

|  |                                  |   |  |  |  |   |  |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Upper Marlboro</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>1731 Ritchie Marlboro Road</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Pinkney</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>21</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>28 May 1930</b>   |  | 9. AGE (In years lost birthday) yrs.<br><b>37</b>                        | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |
| 13. FATHER'S NAME<br><b>Charles Dominic Henson</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Louise Medley</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>—</b>  |  | 17. INFORMANT<br><b>Alfred Pinkney</b> Address <b>Same as 2D</b>         |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b><br><b>443X</b> DUE TO <b>Hypertensive cardio vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>unknown</b>                   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |  | 20f. (City or town) (County) (State)                                     |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                        |                                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b> M.D.   |                                  |   | 22. DATE SIGNED<br><b>9-22-67</b>  |  |  |   |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>  |                                  |   | Address (Street, city, town, or county)  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 23b. DATE THEREOF<br><b>9-25-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Highland Park Md</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>H.S. Washington &amp; Sons</b> ADDRESS <b>4925 Deane Ave</b>  |                                  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 26 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                       |   |  |



*[Faint, mostly illegible text and markings covering the page, including what appears to be a signature at the bottom center.]*

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12892

**CERTIFICATE OF DEATH**

12901

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                               |  |  |  |   |   |  |
|---|-------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>  |                               |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>   |                               |  |  | d. STREET ADDRESS <u>5024-56<sup>th</sup> Ave.</u>   |   |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Waisey E. Glass</u>  |                               |  |  | 4. DATE OF DEATH <u>Sept. 16 1967</u>  |   |   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 1, 1885</u>              | 9. AGE (In years last birthday) <u>82</u> yrs.   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.                       |   | 11. IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>   |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>   |
| 13. FATHER'S NAME <u>Robert Butler</u>  |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>Suit</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |                               |  |  | 16. SOCIAL SECURITY NO. <u>577-07-9263B</u>  |   | 17. INFORMANT <u>Miss Jean M. Glass</u> Address <u>5024-56<sup>th</sup> Ave Hyattsville, Md</u> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>4200 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u><br>DUE TO (c) <u>Unknown</u> |                               |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>  |                               |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                          |  |
| 20f. (City or town) (County) (State)  |                               |  |  |  |   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Sept 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 15</u> , 19 <u>67</u> , and that death occurred at <u>6:15 AM</u> , from causes and on the date stated above.   |                               |  |  |  |   |   |  |
| 22a. SIGNATURE <u>John Kelle</u>  |                               |  |  | ATTENDING MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             |   | 22b. DATE SIGNED <u>9-16-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN H. KELLE</u>   |                               |  |  | 22d. ADDRESS <u>RIVERDALE, MD</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>9-19-67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Wash Natl Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State) <u>Southland Md</u>                               |  |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers Inc</u> Address <u>1400 The Capital NW Washington D.C. 20009</u>  |                               |  |  | 25a. REC'D BY REGISTRAR DATE <u>SEP 19 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>  |  |



100-100000

EXTRACT OF RECORD

100-100000

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                       |  |   |  |   |  |   |  |   |  |
|--|--|---------------------------------------|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                       |  |   |  |   |  |   |  |   |  |
| 12893  |  |                                       |  |   |  |   |  |   |  |   |  |
| 12902  |  |                                       |  |   |  |   |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |                                       |  |   |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |  |                                       |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓<br>a. STATE <b>Maryland</b> b. COUNTY <b>Charles County</b> |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Clinton</b>   |  |                                       |  | c. LENGTH OF STAY IN lb   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Nanjemoy</b>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Pine View Gardens Health Care Center</b>  |  |                                       |  |   |  | d. STREET ADDRESS   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Ernest F. Posey</b>   |  |                                       |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>9 XX 20 19 67</b>  |  |   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-16-82</b>  |  | 9. AGE (In years last birthday)<br><b>85 yrs.</b> |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  |                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Charles County, Md.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Robert Posey</b>   |  |                                       |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Niolet Groves Sarah C. Groves</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |                                       |  | 16. SOCIAL SECURITY NO.<br><b>219-16-1895</b>   |  | 17. INFORMANT Address<br><b>Lillian Davis -Daughter-Nanjemoy, Md.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY COLLAPSE</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRO-VASCULAR-ACCIDENT</b> DUE TO<br>(c) <b>SENILITY - ASCVD</b> |  |                                       |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 MONTHS</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                                       |  |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                       |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)              |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-29</b> , 19 <b>67</b> , to <b>9-20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-20</b> 19 <b>67</b> , and that death occurred at <b>7.20A</b> , from causes and on the date stated above.   |  |                                       |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>C. Alvarado</b>   |  |                                       |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                |  | 22b. DATE SIGNED<br><b>9-20-67</b>                |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DR A.R. LAPIN</b>   |  |                                       |  |   |  | 22d. ADDRESS<br><b>CLINTON, MD</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>9/22/1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nanjemoy Baptist Cemetery Nanjemoy, Md.</b>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)     |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>AREHART FUNERAL HOME, INC. LA PLATA, MD.</b>  |  |                                       |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

CO - Containing 3 pages, 1- by physician, 2- by funeral director, 3- by State Dept. of Health

(M)

12894

Item #9 Film #G392 9/20/67 pn

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12903

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riverdale</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>One day</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Ieland Memorial Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>6015 Springhill Drive</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cora</b> Middle <b>L.</b> Last <b>Prunier</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>09</b> Day <b>11</b> Year <b>19 67</b>   |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/18/91</b>                |  |
| 9. AGE (In years last birthday)<br><b>75 1/2</b> yrs.   |  | 10. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>WASHINGTON, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Brown, Sara</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>Jameson, William</b>  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  |  |
| 16. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT<br><b>Daughter, Guiffre, Ethel, Hyattsville.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>492 X</b> IMMEDIATE CAUSE (a) <b>ACUTE PNEUMONITIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>CONGESTIVE HEART FAILURE</b>   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)               |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-11</b> , 19 <b>67</b> , to <b>9-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-11</b> 19 <b>67</b> , and that death occurred at <b>6:45pm</b> from causes and on the date stated above.               |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>C. J. Houmann</b>  |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>9-11-67</b>                 |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. J. HOUMANN</b>  |  |  |  | 22d. ADDRESS<br><b>RIVERDALE MD.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF<br><b>Sept 14, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery, Calver Manor Park, Md.</b>  |  | 23d. LOCATION (City or Town) (County) (State)      |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur Walters</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 18 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

STATE OF OHIO  
DEPARTMENT OF HEALTH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12904

|   |                                  |  |  |   |   |   |                                |
|---|----------------------------------|--|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>  |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>    |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Landover Hills</b> |   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>   |                                  |  |  | d. STREET ADDRESS<br><b>7104 Merrywood St</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                                |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>W</b> Last <b>Pyles</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>14</b> Year <b>1967</b>   |   |   |                                |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>25 March 1896</b> |   | 9. AGE (In years last birthday)<br><b>71</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PAINTER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSE PAINTER</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13. FATHER'S NAME<br><b>JOHN D. PYLES</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELLEN J. ROBERTS</b>   |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |  | 17. INFORMANT<br><b>IRENE E. PYLES - 7104 MARYWOOD ST HYATTSVILLE, MD.</b>  |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rupture of aneurysm of abdominal aorta</b><br><b>451x</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>_____ |                                  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b>  |                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                        |                                  |  |  |   |   |   |                                |
| ACTUAL SIGNATURE<br><br>EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>  |                                  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>9-15-67</b> |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>SEPT. 18, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN CEM.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BLADENSBURG MD.</b>   |                                |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS Co. RIVERDALE, MD.</b>   |                                  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 19 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br> |                                |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12896

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12905

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |  |   |  |   |   |  |
|--|----------------------------------|--|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  |  |   | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>  |                                  |  |   | d. STREET ADDRESS<br><b>4505 Church Street</b>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Stanley</b> Middle <b>L</b> Last <b>Queen</b>  |                                  |  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>11</b> Year <b>19 67</b>   |   |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4 April 1902</b> |  | 9. AGE (In years last birthday)<br><b>65</b> yrs. | 10. IF UNDER 1 YEAR<br>Months <b>16</b> Days <b>1</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self-employed</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>George Queen</b>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Carrie Johnson</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Marion Queen-4505 Church Street</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the esophagus</b><br><b>150x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____  |                                  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>over 2 mo</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |  |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe, M.D.</b><br>EXAMINER'S NAME (Type)  |                                  |  |   | 22. DATE SIGNED<br><b>9-12-67</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/15/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>                          |  |
| 24. FUNERAL DIRECTOR<br><b>Stewart Funeral Home</b>  |                                  |  |   | 25a. REC'D BY REGISTRAR<br><b>SEP 15 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12906

|  |                                  |   |   |  |   |  |  |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Morningside</b>   |   | d. STREET ADDRESS<br><b>103 Woodlawn Road</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George General Hospital</b>  |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ivey</b> Middle <b>V.</b> Last <b>Rainwater</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>12</b> Year <b>19 67</b>   |   |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>21 Oct. 1913</b> | 9. AGE (In years lost birthday)<br><b>53</b> yrs   | IF UNDER 1 YEAR<br>Months <b>53</b> Days <b>12</b> Hours <b>19</b> Min. | IF UNDER 24 HRS.<br>Hours <b>12</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Government</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Ivey Vason Rainwater Sr.</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella Mary Peacock</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>WW II</b>   |   | 17. INFORMANT Address<br><b>Frances B. Rainwater, Same As # 2</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4200</b><br>DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____   |                                  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>over 5 yrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |  |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |                                  | M.D.<br><b>John Kehoe, M.D.</b>   |   | 22. DATE SIGNED<br><b>9-12-67</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9/14/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Gardens Cemetery, Fredericksburg, Va.</b>   |   | 23d. LOCATION (City or Town) (County) (State)  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Wilhelm Funeral Home</b><br><b>4308 Suitland Road, Suitland, Maryland</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 18 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

2005-2006

5110

11. *Other* \_\_\_\_\_

1154

• *Journal of Management Education* 24(10):1103-1114

4308 Bedford Road, Springfield, Virginia 22154

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12898

CERTIFICATE OF DEATH

12907

|  |                               |   |                                       |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>           |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |                               | c. LENGTH OF STAY IN 1b <b>12 days</b>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>  |                               | d. STREET ADDRESS <b>4924 Laffette Street</b>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Albert</b> Middle <b>A</b> Last <b>Raulin sr</b>   |                               | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>23</b> Year <b>1967</b>   |                                       |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>20 Jan., 1908</b> |
| 9. AGE (In years lost birthday) <b>59</b> yrs.   |                               | 10. IF UNDER 1 YEAR <b>16-1</b><br>Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>   |                                       |
| 13. FATHER'S NAME <b>August Raulin</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Lillian Gebhardt</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>  |                               | 16. SOCIAL SECURITY NO. <b>577 05 5750</b>  |                                       |
| 17. INFORMANT <b>Genevieve Raulin</b>  |                               | Address <b>Edmonston, Md.</b>   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Failure</b><br>5810 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hepatic Cirrhosis</b><br>DUE TO<br>(c) |                               | INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (a) (this hospital) attended the deceased from <b>9/12</b> , 1967, to <b>9/23</b> , 1967 that (H) (we) lost saw the deceased alive on <b>9/23</b> , 1967, and that death occurred at <b>3:45 PM</b> from causes on and on the date stated above.  |                               |   |                                       |
| 22a. SIGNATURE <b>Roberts Burroughs</b>  |                               | 22b. DATE SIGNED <b>Sept 24, 1967</b>   |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>ROBERTS, BURROUGHS</b>   |                               | 22d. ADDRESS <b>1201 St. Upper Marlboro, Md.</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>Sept 27, 1967</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>   |                                       |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>  |                               | 25a. REC'D BY REGISTRAR <b>SEP 27 1967</b>  |                                       |
| Address <b>Hyattsville, Md.</b>  |                               | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |                                       |

• 3952

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |   |   |   |  |
|---|--|---|---|---|--|---|---|---|--|
| 12899 Items #7 & 9 Film #G393 10/2/67 PH<br>Item #2c & d Film #G393 10/11/67 PH   |  |   |   |   | 12908  |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cheverly  |  |   | c. LENGTH OF STAY IN 1b<br>12 days  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Forestville / Cottage City 16-1                  |   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Prince George's General Hsopital  |  |   |   |   | d. STREET ADDRESS 3709 42nd Ave.<br>Regent Nursing Home  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Virginia Reid   |  |   |   |   | 4. DATE OF DEATH<br>Month Day Year<br>Sept. 3 1967   |   |   |   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>Cauc.                     |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>7-21-10   |   | 9. AGE (In years last birthday) yrs.<br>56/57   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home |   | 11. BIRTHPLACE (County & State, or foreign country)<br>Washington D. C.   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U S A.      |   |  |
| 13. FATHER'S NAME<br>Harry Baker  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br>Mary Widmeier  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>no   |  |   | 16. SOCIAL SECURITY NO.<br>579 48 6332  |   | 17. INFORMANT<br>Address<br>Ronald J Reid Temple Hills, Md   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 260X Cardiac Arrest, Congestive Heart Failure<br>DUE TO (b) Anteriosclerotic Heart Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes mellitus. |  |   |   |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)        |   |  |
| 21. I certify that (he) (this hospital) attended the deceased from 8-22, 1967, to 9-3, 1967, that (he) (we) last saw the deceased alive on Sept. 3, 1967, and that death occurred at 3:35A M, from causes and on the date stated above.   |  |   |   |   |  |   |   |   |  |
| 22a. SIGNATURE<br>T. Hernandez, M.D.  |  |   |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>      |   |   | 22b. DATE SIGNED<br>9/3/67  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>T. Hernandez, M. D.   |  |   |   |   | 22d. ADDRESS<br>Prince Georges General Hosspital   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>Sept 6, 1967             |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft Lincoln Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Colmar Manor Pro Geo Md. |   |   |  |
| 24. FUNERAL DIRECTOR<br>F. Gasch's Sons Hyattsville, Md.  |  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE SEP 8 1967   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |   |  |



DECLARATION OF DEATH

Princess George's Hospital, London, England

11 days

Princess George's General Hospital

Sold

7-11-10

Female

Princess George's

no

T. Harbinger, M.D.

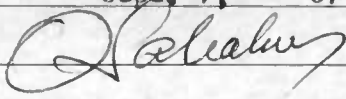
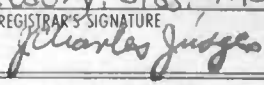
Princess George's General Hospital

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12900

12909

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b>  |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>4 days</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>Rt. 2, Box 56-A</b>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Mary B. Rhinehart</b>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 7, 1967</b>  |  |  |   |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 9, 1902</b>                              |   |
| 9. AGE (In years last birthday)<br><b>65 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                           |   |
| 13. FATHER'S NAME<br><b>Turner</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Florence Cooke</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>217-30-0522</b>  |  | 17. INFORMANT<br><b>Mrs. Margaret E. Waterhouse</b><br><b>428 B. Crescent Rd., Greenbelt, Md.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lympho Sarcoma terminal</b><br>DUE TO <b>2001</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Severe Anemia due to H<sub>2</sub>O</b><br>DUE TO<br>(c) |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>one year</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                 |   |
| 21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1965</b> , 19 <b>Sept. 7, 1967</b> , that (I) <del>(the)</del> last saw the deceased alive on <b>Sept. 7, 1967</b> , and that death occurred at <b>9 p. M.</b> from causes and on the date stated above.  |  |  |  |   |  |  |   |
| 22a. SIGNATURE<br>  |  |  |  | 22b. DATE SIGNED<br><b>Sept 8, 67</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Johannes Sahakyan, M. D.</b>      |   |
| 22d. ADDRESS<br><b>6001 Landover Rd. Cheverly, Maryland</b>  |  |  |  | 22e. ADDRESS<br><b>6001 Landover Rd. Cheverly, Maryland</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF<br><b>Sept. 11, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Memorial Gardens</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Waldorf, Md.</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Funeral Home</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 13 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED IN THE OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315

LETTER OF CREDIT

3

Prince Georges Hospital, Prince Georges, Maryland

Account of the above

Prince Georges Hospital, Prince Georges, Maryland

Prince Georges Hospital, Prince Georges, Maryland

Prince Georges Hospital, Prince Georges, Maryland

*[Faint, mostly illegible handwritten text, possibly a signature or address block]*

Prince Georges Hospital, Prince Georges, Maryland

*[Faint, mostly illegible handwritten text at the bottom of the page]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

12901

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12910

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince George's</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General</b>   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince George's</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Berwyn Heights</b><br>d. STREET ADDRESS<br><b>8450 57th Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lawrence N. Ricker</b>  |  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>24</b> Year <b>1967</b>   |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>2/2/14</b>  |  | 9. AGE (In years last birthday)<br><b>53</b> yrs.  |   | IF UNDER 1 YEAR<br>Months <b>16</b> Days <b>1</b> Hours <b>1</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>PLUMBING</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON D.C.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 13. FATHER'S NAME<br><b>LAWRENCE N. RICKER</b>   |   |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>VIOLA SCHNEIDER</b>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |   |   |  |
| 16. SOCIAL SECURITY NO.<br><b>577 269194</b>   |  | 17. INFORMANT<br><b>Sally Ricker (Wife)</b> Address<br><b>Same as #2</b>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Abscesses of Right Lung</b><br>DUE TO (b) <b>Epidermoid Carcinoma of the right epiglottal fold and pyriform sinus.</b><br>DUE TO (c) <b>1 month</b>   |  |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <b>None</b>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>          |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>None</b> p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>None</b>   |  |
| 20f. (City or town)<br><b>None</b>   |  | 20g. (County)<br><b>None</b>   |   | 20h. (State)<br><b>None</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><b>9/25/67</b>   |  |
| EXAMINER'S NAME (Type)<br><b>JOHN KEHOE</b>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| Address (Street, city, town, or county)<br><b>RIVERDALE, MD</b>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>SEPT 28, 1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN CEM</b>   |  |
| 23d. LOCATION (City, town or county)<br><b>BLADENSBURG, MARYLAND</b>   |  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS Co. RIVERDALE, MD</b>   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 28 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 12902   |                                    | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 12911  |   |
|---|------------------------------------|---|--|--|---|
| CERTIFICATE OF DEATH  |                                    |   |  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                    |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b> |  |   |
| c. LENGTH OF STAY in 1b<br><b>2 hrs. 25mins.</b>  |                                    |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mitchellville</b>   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |                                    |   | d. STREET ADDRESS<br><b>Rt. #2, Box 105, Rt. 301</b>   |  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Baby Girl Roberts</b>   |                                    |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 6, 1967</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 6, 1967</b>   |  | 9. AGE (In years lost birthday) yrs.<br><b>2</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Prince George's, Maryland</b>      |   |
| 13. FATHER'S NAME<br><b>Berwyn Andrew Proctor</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Esther Deloris Roberts</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mother</b><br>Address<br><b>Same as above</b>                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>prematurity</u><br>DUE TO (b) <u>Atelectasis, Bilateral</u><br>DUE TO (c) <u>lost.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                    |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                    |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |   |
| 20f. (City or town)   |                                    | (County)  |  | (State)  |   |
| 21. I certify that (this hospital) attended the deceased from <b>Sept. 6, 1967</b> , to <b>Sept. 6, 1967</b> , that (we) last saw the deceased alive on <b>Sept. 6, 1967</b> , and that death occurred at <b>5:10 PM</b> from causes and on the date stated above.  |                                    |   |  |  |   |
| 22a. SIGNATURE<br><i>[Signature]</i>  |                                    | 22b. DATE SIGNED<br><b>9/9/67</b>   |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Iradj Mahadavi, M. D.</b>                                 |   |
| 22d. ADDRESS<br><b>6821 Riverdale Road, Cheverly, Md.</b>   |                                    | 22e. REC'D BY REGISTRAR<br><b>SEP 19 1967</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                                    | 23b. DATE THEREOF<br><b>9-16-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prince George's Gen. Hosp. Cheverly PG Maryland</b> |   |
| 24. FUNERAL DIRECTOR<br><b>William A. Parker, Asst. Admin., Cheverly, Md.</b>   |                                    | 25. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |



1940

Prince George

Barbados

John George

1000 N. 1st St. N. W. Wash. D. C.

1000 N. 1st St. N. W. Wash. D. C.

1000 N. 1st St. N. W. Wash. D. C.

Robert

Cliff

Baby

John George

1000 N. 1st St. N. W. Wash. D. C.

1000 N. 1st St. N. W. Wash. D. C.

1000 N. 1st St. N. W. Wash. D. C.

1000 N. 1st St. N. W. Wash. D. C.

Mother

1000 N. 1st St. N. W. Wash. D. C.

X

1000 N. 1st St. N. W. Wash. D. C.

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1000 N. 1st St. N. W. Wash. D. C.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with funeral home's report. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

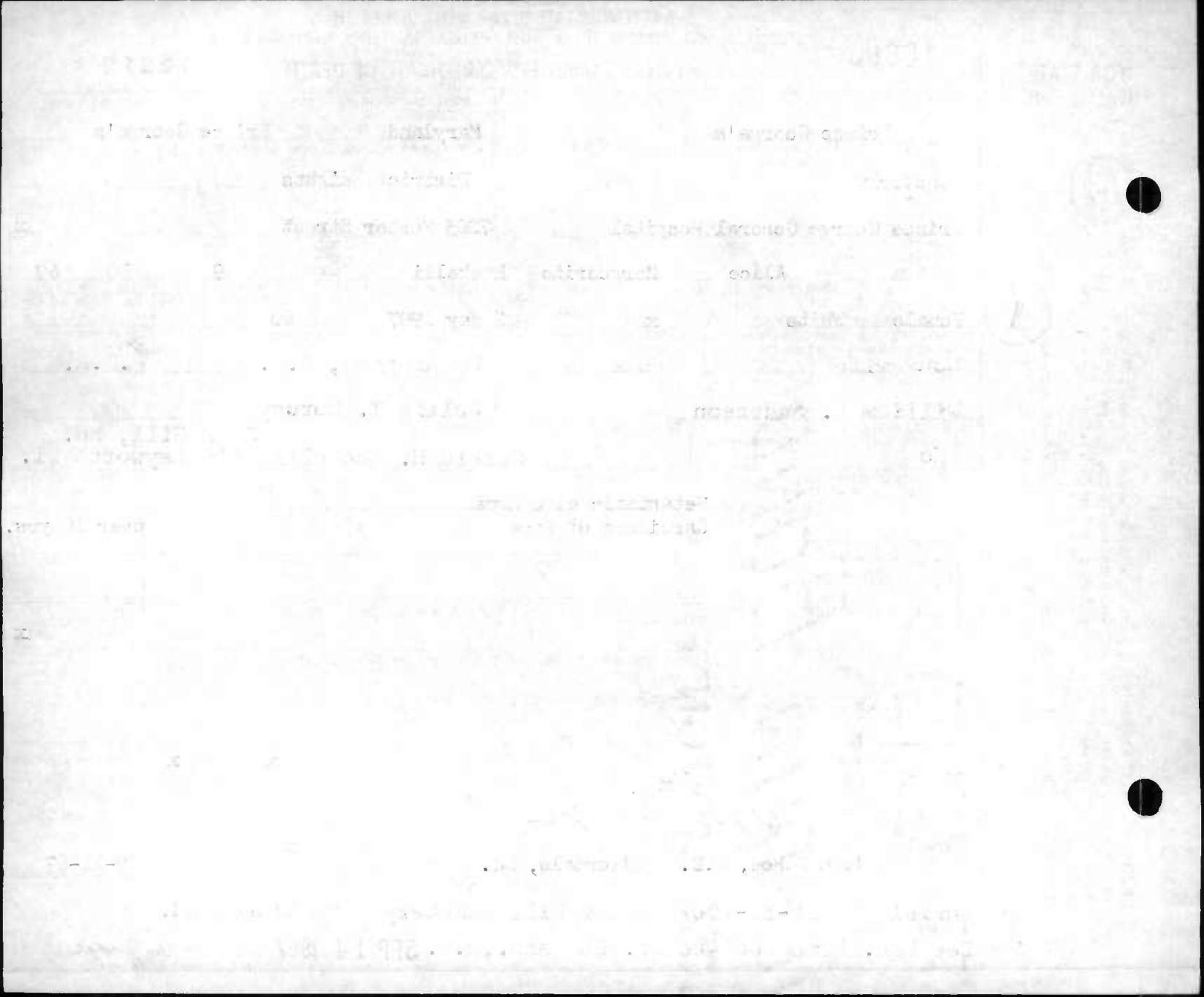
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12903

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12912

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>  |   | c. LENGTH OF STAY IN 1b <b>DOA</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>  |   | d. STREET ADDRESS <b>7205 Foster Street</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Alice Marguerite Rockelli</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>9 10 19 67</b>   |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2 May 1907</b>  |
| 9. AGE (In years last birthday) <b>60</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13. FATHER'S NAME <b>William E. Anderson</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Nellie T. Hurney</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT <b>Gerald H. Rockelli</b>   |   | Address <b>Oxon Hill, Md. 4414 Hayworth Pl.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b><br><b>1970</b> DUE TO <b>Carcinoma of face</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>over 10 yrs.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |   | 22. DATE SIGNED<br><b>9-11-67</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town) (County) (State)   |
| <b>Burial</b>   | <b>10-13-1967</b>   | <b>Cedar Hill Cemetery</b>  | <b>Suitland, Md.</b>  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Lee Fun. Home 300 4th St. NE Wash., D.C.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>SEP 14 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

VR A15 (4)  
25M 1/67

12904

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12913

CERTIFICATE OF DEATH THERESA JACQUELINE ROCKS

|  |                        |   |                          |
|--|------------------------|---|--------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George's MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George's                    |                          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly  |                        | c. LENGTH OF STAY IN 1b 4 days  |                          |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital  |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                          |
| 3. NAME OF DECEASED (Type or print) Baby Girl Rocks  |                        | 4. DATE OF DEATH Sept. 4 19 67  |                          |
| 5. SEX Female  | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-31-67 |
| 9. AGE (In years lost birthday) yrs. 16.1  |                        | 10. IF UNDER 1 YEAR Months 4 Days 4 Hours Min.  |                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                        | 10b. KIND OF BUSINESS OR INDUSTRY   |                          |
| 11. BIRTHPLACE (County & State, or foreign country) Prince George's, Md.   |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |                          |
| 13. FATHER'S NAME John Rocks   |                        | 14. MOTHER'S MAIDEN NAME Jacqueline Susan Mongeon   |                          |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No   |                        | 16. SOCIAL SECURITY NO. ----  |                          |
| 17. INFORMANT John V. Rocks, 2607 Hughes Rd Adelphi  |                        | Address   |                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis<br>(b) Prematurity<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) |                        | INTERVAL BETWEEN ONSET AND DEATH  |                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                        | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                          |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19   |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                          |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                        | 20f. (City or town) (County) (State)  |                          |
| 21. I certify that (1) (physician) attended the deceased from 8-31, 19 67, to 9-4, 19 67, that (1) (xx) last saw the deceased alive on 9-3, 19 67, and that death occurred at 2:15 p.m. from causes and on the date stated above.  |                        |   |                          |
| 22a. SIGNATURE John Perkins  |                        | 22b. DATE SIGNED 9-5-67   |                          |
| 22c. PHYSICIAN'S NAME (Type) John Perkins, M. D.   |                        | 22d. ADDRESS 6201 Riverdale Rd., Riverdale, Md.   |                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 23b. DATE THEREOF Sept 6, 1967  |                          |
| 23c. NAME OF CEMETERY OR CREMATORY Date of Heaven Cemetery   |                        | 23d. LOCATION (City or Town) (County) (State) Montgomery Co Md  |                          |
| 24. FUNERAL DIRECTOR John H. Watters 254 Carroll St NW Wash DC   |                        | 25a. REC'D BY REGISTRAR DATE SEP 6 1967   |                          |
| 25b. REGISTRAR'S SIGNATURE Charles Judge   |                        |   |                          |

7-279714

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

Prince George's  
Adelphi  
2007 N. 1st St.  
Baltimore, Md.

John W. Moore  
2-11-27  
Baltimore, Md.

Prince George's  
Baltimore, Md.

John W. Moore  
Baltimore, Md.

John W. Moore  
Baltimore, Md.

John W. Moore  
Baltimore, Md.

John W. Moore  
Baltimore, Md.

John W. Moore  
Baltimore, Md.

John W. Moore  
Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12905

12914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |  |  |   |  |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence-before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY <b>473</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural (Glenn Dale)</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>9 mo. 27 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Glenn Dale Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>5325 Chillum Place, N.E.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Walter</b> Middle <b>H.</b> Last <b>Ross</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>22</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 16, 1881</b> | 9. AGE (In years lost birthday) yrs.<br><b>85</b>  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes unknown</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |  | 17. INFORMANT Address<br><b>D.C. General Hospital Washington, D.C.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4200 Arteriosclerotic heart disease with congestive heart failure</b><br>DUE TO (b) <b>Generalized arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>unknown</b> |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Old cerebrovascular accidents.</b>  |                                  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/25, 1966</b> , to <b>9/22, 1967</b> that (I) (we) last saw the deceased alive on <b>9/22, 1967</b> , and that death occurred at <b>9:25 P.M.</b> from causes and on the date stated above.  |                                  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Moe Weiss</b>  |                                  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  | 22b. DATE SIGNED<br><b>Sept. 22, 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Moe Weiss, M.D.</b>  |                                  |   |  | 22d. ADDRESS<br><b>Glenn Dale Hospital, Glenn Dale, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9/27/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Memorial Park Maryland</b>  |  | 23d. LOCATION (City or Town) (County) (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>Stewart Funeral Home</b>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>SEP 27 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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14

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2000

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1. The first part of the paper is devoted to the study of the asymptotic behavior of the solutions of the system (1) as  $t \rightarrow \infty$ . It is shown that the solutions of the system (1) tend to zero as  $t \rightarrow \infty$  if and only if the matrix  $A$  is stable.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12906

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12915

|   |                               |  |                                      |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>       |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>  |                                      |
| c. LENGTH OF STAY IN 1b <b>30 YRS</b>   |                               | 16.1   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>16 L Ridge Road</b>   |                               | d. STREET ADDRESS <b>16 L Ridge Road</b>   |                                      |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                      |
| 3. NAME OF DECEASED (Type or print) <b>Lester Michael Sanders</b>   |                               | 4. DATE OF DEATH <b>9 27 19 67</b>   |                                      |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>17 June 1906</b> |
| 9. AGE (In years lost birthday) <b>61</b> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACT SPECIALIST</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                      |
| 13. FATHER'S NAME <b>DANIEL SANDERS</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>ESTELLE JONES</b>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>  |                               | 16. SOCIAL SECURITY NO. <b>577-05-7922</b>   |                                      |
| 17. INFORMANT <b>MARIE SANDERS</b>  |                               | Address <b>16-L RIDGE RD GREENBELT, MD</b>   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>443X<br>DUE TO <b>Hypertensive cardio vascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus - over 10 years</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>minutes over 5 yrs.</b>  |                                      |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work  |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |                               |  |                                      |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.   |                               | 22. DATE SIGNED <b>9-28-67</b>   |                                      |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>   |                               | Address (Street, city, town, or county)  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 23b. DATE THEREOF <b>SEPT. 30, 1967</b>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>BLADENSBORO, MD</b>   |                                      |
| 24. FUNERAL DIRECTOR <b>W.W. CHAMBERS Co RIVERDALE, MD</b>  |                               | 25a. REC'D BY REGISTRAR <b>OCT 2 1967</b>  |                                      |
| 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>  |                               |  |                                      |





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

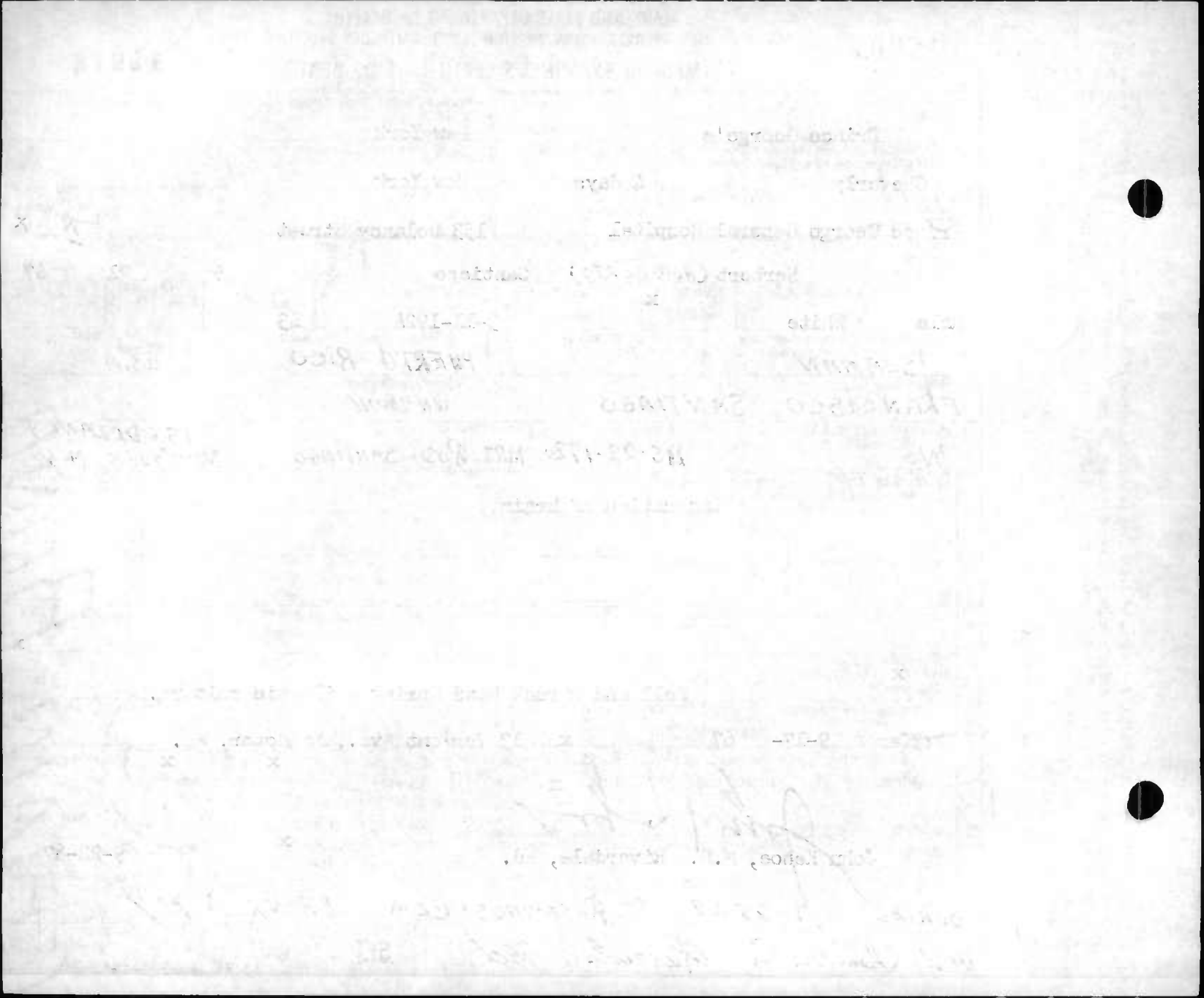
FOR STATE  
HEALTH DEPT.

12907

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12916

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>New York</b><br>b. COUNTY <b>New York</b>           |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |  |   |  | c. LENGTH OF STAY IN IB <b>4 days</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>Herbert (HERIBERTO) Santiago</b>  |  |   |  | 4. DATE OF DEATH <b>9 21 19 67</b>   |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3-11-1924</b>                             |  |
| 9. AGE (In years last birthday) <b>43</b> yrs.   |  | IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b> Hours <b>19</b> Min. <b>67</b> |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMAN</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>PUERTO RICO</b>          |  |
| 11. BIRTHPLACE (State or foreign country) <b>PUERTO RICO</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  |   |  |
| 13. FATHER'S NAME <b>FRANCISCO SANTIAGO</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>115-22-1720</b>   |  | 17. INFORMANT <b>MRS. ROSA SANTIAGO</b>                       |  |
| 18. Address <b>153 DELANCY NEW YORK N.Y</b>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3533</b> IMMEDIATE CAUSE (a) <b>Laceration of brain</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b><br>(c) <b>DUE TO</b>   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Fell and struck head during epileptic seizure.</b>   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <b>9-17-19 67</b><br>Hour a.m. <b>11:30am</b> P.m. <b>9-17-19 67</b>  |  |   |  | 20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>               |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2413 Vermont Ave., Landover, Md.</b>   |  |   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.  |  |   |  | 22. DATE SIGNED <b>9-22-67</b>   |  |   |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>  |  |   |  | Address (Street, city, town, or county)  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>9-25-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. RAYMONDS CEM</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>BRONX NY</b> |  |
| 24. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Riverdale Md.</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>SEP 25 1967</b>   |  |   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12908

CERTIFICATE OF DEATH

12917

|   |                                    |   |   |   |   |  |  |
|---|------------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>27 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |                                    |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Aguasco</b><br>d. STREET ADDRESS<br><b>15-1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Charity Elizabeth Savoy</b>   |                                    |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>September 11, 1967</b>   |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/4/1888</b>               |   | 9. AGE (In years lost birthday)<br><b>79</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>P. Ges. Co. Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Aguostas Brooks</b>   |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Claster Battey</b> |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Mrs. Marie Douglass</b> Address<br><b>Aguasco, Md.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular accident</b><br><b>4221</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                    |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>27 days</b>                           |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <del>it</del> (this hospital) attended the deceased from <b>August 25, 1967</b> , to <b>Sept. 11, 1967</b> , that <del>it</del> (we) last saw the deceased alive on <b>Sept. 11, 1967</b> , and that death occurred at <b>1:40PM</b> , from causes and on the date stated above.   |                                    |   |   |   |   |  |  |
| 22a. SIGNATURE<br><b>A. Clark Holmes</b>  |                                    |   |   | 22b. DATE SIGNED<br><b>Sept. 12, 1967</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>A. Clark Holmes, M. D.</b>                |  |
| 22d. ADDRESS<br><b>Prince Georges General Hospital</b>  |                                    |   |   | 22e. REC'D BY REGISTRAR<br><b>SEP 21 1967</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 23b. DATE THEREOF<br><b>Sept. 16, 1967</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Philip Ch. Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Aguasco, P. Ges. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Marcell Adams</b>  |                                    | ADDRESS<br><b>Aguasco, Md.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |  |  |

STATE OF TEXAS  
COUNTY OF DALLAS

17 days

Prince George's General Hospital

General

19/12/82

Colored

Cardiac arrest or accident

27 days

August 11, 1957

Sept. 11, 1957

Sept. 11, 1957

Prince George's General Hospital

Dr. Clark H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12909

CERTIFICATE OF DEATH

12918

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>PRINCE GEORGE'S</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>MARYLAND</b><br>b. COUNTY <b>PR. GEO.</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CLINTON,</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>(9-28 to 9-29-67)</b>   |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OXON HILL, MARYLAND</b>   |                                  | 16.1  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>PINE VIEW GARDENS HEALTH CARE CTR.</b>  |                                  | d. STREET ADDRESS<br><b>5265 Shago Drive</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>THOMAS N. SHERIFF</b>  |                                  | 4. DATE OF DEATH<br>Month <b>09</b> Day <b>29</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-23-84</b>           |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min.   | 11. IF UNDER 24 HRS.<br>Hours <b>00</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Blacksmith</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>mechanic</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Oxon Hill, Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Henry E. Sheriff</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Hatton</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Pine View Gardens Health Care Center</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA of PT. LIVER - Metastatic</b><br>199.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Anemia</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/26/1967</b> to <b>9/29/1967</b> that (I) (we) last saw the deceased alive on <b>9/29/1967</b> , and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Dr. Sadeghian</b>   |                                  | 22b. DATE SIGNED<br><b>9/29/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>IRADJ. SADEGHIAN M.D.</b>   |                                  | 22d. ADDRESS<br><b>11200 LOCKWOOD DR SILVER SPRING MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Oct. 2-1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Simmons Bros.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>OCT 2 1967</b>  |  |
| ADDRESS<br><b>Wash., DC</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

STATEMENT OF SERVICE

NAME OF SIGNED  
DATE OF SERVICE

NAME OF SIGNED  
DATE OF SERVICE

NAME OF SIGNED  
DATE OF SERVICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #3 Film #G393 10/13/67

12910

CERTIFICATE OF DEATH

12919

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Prince George</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>818 8th St</u>  |   | d. STREET ADDRESS <u>818 8th St</u>  |   |
| 3. NAME OF DECEASED (Type or print) <u>EDGAR W. SHIVER</u>  |   | 4. DATE OF DEATH <u>Sept 28 1967</u>   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/24/1903</u>   |
| 9. AGE (In years last birthday) <u>64</u> yrs.  |   | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>US Ganta Locator Co. Georgia</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>William C. Shiver</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Kella Tabliss</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |   | 16. SOCIAL SECURITY NO. <u>253-12-496</u>  |   |
| 17. INFORMANT <u>Mrs Edgar Shiver - Rhone</u>   |   | Address <u>  </u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO <u>  </u><br>(b) <u>Intense - Excessive Heart Disease</u><br>DUE TO <u>  </u><br>(c) <u>Pulmonary Embolism</u>            |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>  </u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>  </u> , to <u>9/28</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>9/28</u> , 19 <u>67</u> , and that death occurred at <u>4:00</u> P.M. from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE <u>Robert C. Wingfield</u>   |   | 22b. DATE SIGNED <u>9/29/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD, M.D.</u>   |   | 22d. ADDRESS <u>329 PRINCE GEORGE STREET LAUREL, MARYLAND 20810</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>10-2-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem. Champanille, Georgia</u>  | 23d. LOCATION (City or Town) (County) (State)                                       |
| 24. FUNERAL DIRECTOR <u>W. W. Dandean Laurel, Md</u>  |   | 25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |
| DATE <u>OCT 2 1967</u>  |   |  |   |

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
OCT 2 1961

ROBERT D. INGLETON

WILLIAM C. GEORGE

OCT 2 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12911 CERTIFICATE OF DEATH 12920

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>PRINCE GEORGE</b>  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>HYATTSVILLE</b>                               |  | c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>PRINCE GEORGE</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Residence 6700 BELCREST RD. Apt 117</b>  |  | e. STREET ADDRESS<br><b>6700-BELCREST RD. Apt 117</b>  |  | f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Magdalene Greenwell Short</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept 27 1967</b>  |  | 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>JAN. 7-1891</b>  |  | 9. AGE (in years last birthday)<br><b>76 yrs.</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U.S. GOVERNMENT BUREAU OF E &amp; P.</b> |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>WASHINGTON D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>DANIEL C. GREENWELL (RETIRED)</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET S. PFEIFFER</b>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>579-60-7042</b>          |  | 16. SOCIAL SECURITY NO.<br><b>MISS MARION E GREENWELL</b>  |  | 17. INFORMANT<br><b>Address 6700 BELCREST RD - HYATTSVILLE</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the Cervix with Metastasis</b><br>DUE TO (b) <b>171X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>171X</b><br>DUE TO (c) <b>171X</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1967</b> to <b>Sept 27, 1967</b> that (I) (we) last saw the deceased alive on <b>Sept 25, 1967</b> , and that death occurred at <b>15 M</b> , from the causes and on the date stated above.   |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Angus W. McLaurin</b>  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>7/27/67</b>  |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ANGUS W. MCLAURIN</b>  |  | 22d. ADDRESS<br><b>3415 Hamilton St - Hyattsville</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Sept. 30, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chapel Hill Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Suitland, Pr. Geo. Co Md.</b>                                     |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>J. Arthur Walters</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 25 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |  |   |  |

13-20

1

SEP 2 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12912

CERTIFICATE OF DEATH

12921

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>District of Columbia</b> b. COUNTY                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>17 Years</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sacred Heart Home, 5805 Queens Chapel Rd.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Julia</b> Middle <b>R.</b> Last <b>Sikken</b>   |                                  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>10</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 4, 1878</b> |
| 9. AGE (In years last birthday) yrs.<br><b>88</b>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerical</b>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b>  |   |
| 13. FATHER'S NAME<br><b>Melvin P. Sikken</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alice E. Flynn</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Sacred Heart Home, Hyattsville, Maryland</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>DUE TO (b) <b>Diabetes mellitus</b><br>DUE TO (c) <b>Arteriosclerosis</b>                                |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 wks.</b><br><b>5 yrs.</b><br><b>30 yrs.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Carcinoma breasts</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2/10, 1948</b> , to <b>9/10, 1967</b> , that (I) (we) last saw the deceased alive on <b>9/7, 1967</b> , and that death occurred at <b>11:30 A.M.</b> from causes and on the date stated above. |                                  |   |   |
| 22a. SIGNATURE<br><b>E.H. Aschenbach</b>  |                                  | 22b. DATE SIGNED<br><b>9/10/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E.H. Aschenbach, M.D.</b>  |                                  | 22d. ADDRESS<br><b>1841 Col. Rd., N.W. D.C. 20009</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>9-13-67</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT OLIVET CEMETERY</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>WASHINGTON, D.C.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>F.J. COLLINS</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>SEP 13 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>F.J. COLLINS</b>   |                                  | 25c. ADDRESS<br><b>3821-14 ST. N.W. D.C.</b>  |   |

STATEMENT OF WITNESSES

Name of witness

Address of witness

Date of statement

Signature of witness

Statement of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Signature of witness

Statement of witness



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12913

CERTIFICATE OF DEATH

12922

|   |                           |   |                               |
|---|---------------------------|---|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Prince Georges MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE D.C. b. COUNTY  |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Glenn Dale (rural)  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Washington 47.3   |                               |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Glenn Dale Hospital, Glenn Dale, Md.  |                           | d. STREET ADDRESS<br>2231 Ontario Rd. N.W.  |                               |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Hector Simon  |                           | 4. DATE OF DEATH<br>Month Day Year<br>9 2 19 67   |                               |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>6/30/1930 |
| 9. AGE (In years lost birthday)<br>37 yrs.  |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.<br>2 0 0 0  |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Assistant Engineer   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Unknown  |                               |
| 11. BIRTHPLACE (County & State, or foreign country)<br>South Carolina   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                               |
| 13. FATHER'S NAME<br>Elliott Simon  |                           | 14. MOTHER'S MAIDEN NAME<br>Carrie C. Moses   |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>249-46-5677  |                               |
| 17. INFORMANT<br>Decedent   |                           | Address   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 0021<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Postoperative Empyema & Bronchopulmonary Fistula<br>(c) Pulmonary Tuberculosis<br>INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>36 days<br>14 mos. |                           |   |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Rightupper lobectomy, 7/27/67; rt. thoracoplasty, 8/31/67  |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br>19  |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |                               |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                               |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/17/66, 19 67, to 9/2, 19 67, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9/2/ 19 67, and that death occurred at 10:45 PM from causes and on the date stated above.   |                           |   |                               |
| 22a. SIGNATURE<br>Moe Weiss   |                           | 22b. DATE SIGNED<br>9/2/67  |                               |
| 22c. PHYSICIAN'S NAME (Type)<br>Moe Weiss, M D.   |                           | 22d. ADDRESS<br>Glenn Dale Hospital,<br>Glenn Dale, Maryland  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 23b. DATE THEREOF<br>9-9-67   |                               |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Harmony Cemetery  |                           | 23d. LOCATION (City or Town) (County) (State)<br>Lumberton - Pr. Geo. Md.   |                               |
| 24. FUNERAL DIRECTOR<br>S. J. Luke  |                           | 25. REC'D BY REGISTRAR<br>SEP 13 1967   |                               |
| 25b. REGISTRAR'S SIGNATURE<br>J. H. Jones   |                           | 25c. REGISTRAR'S SIGNATURE  |                               |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all blank papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2d Film #G393 10/11/67 ph

CERTIFICATE OF DEATH

12914

12923

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince Georges</b>     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |   | c. LENGTH OF STAY IN 1b<br><b>14 days</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>  |   | d. STREET ADDRESS<br><b>Greenbelt</b><br><b>407 Hill Side Rd.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Elizabeth</b> <b>Simons</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept.</b> <b>30</b> <b>19</b> <b>67</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>16 July 1882</b>   |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.   |   | 10. UNDER 1 YEAR<br>Months Days   | 11. IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Dennis Sheehan</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Gilligan</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>218-54-9708JL</b>   |   |
| 17. INFORMANT<br><b>Elizabeth Klem</b>  |   | Address<br><b>Md. 4-D Hillside Rd, Greenbelt,</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arterio-sclerotic heart disease &amp; heart failure</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarct. &amp; atrial flutter</b><br>DUE TO (c) <b>Cerebrovascular accident due to emboli</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 week</b><br><b>24 hour</b>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept 16th, 1967</b> , to <b>Sept 30th, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept 30th, 1967</b> , and that death occurred at <b>10.50 PM</b> from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Till Bergemann</b>   |   | 22b. DATE SIGNED<br><b>10-1-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Till Bergemann, M.D.</b>   |   | 22d. ADDRESS<br><b>Greenbelt, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Oct. 4, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Sepulchre Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rochester Monroe N.Y.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch &amp; Sons</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 4 1967</b>  |   |
| ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

12-23

STATE OF TEXAS

Prison Records

Prison Records

Prison Records

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12915

CERTIFICATE OF DEATH

12924

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>, Maryland</b> b. COUNTY <b>Prince George's</b>        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville</b>   |                                  | 16-1  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>  |                                  | d. STREET ADDRESS<br><b>3833 Hamilton St.</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Carolyn</b> Middle <b>Smith</b> Last <b>Smith</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>2</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>March 23, 1918</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>49</b>  |                                  | IF UNDER 1 YEAR<br>Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min. <b>49</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ohio</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |   |
| 13. FATHER'S NAME<br><b>Ralph O Flickinger</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Carrie Montgomery</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>579 28 7721</b>   |   |
| 17. INFORMANT<br><b>Edward P Smith</b>   |                                  | Address<br><b>Hyattsville, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized peritonitis</b><br>DUE TO <b>intestine obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>recurrent intestinal adhesions</b><br>(c) <b>adhesions</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 19 67</b> to <b>Sept. 2, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Sept 2, 19 67</b> , and that death occurred at <b>2:20 PM</b> , from causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Don B. Cameron</b> M.D.   |                                  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>DON B. CAMERON</b>  |                                  | 22b. DATE SIGNED<br><b>9-2-67</b>   |   |
| 22d. ADDRESS<br><b>8503 PERRY ST</b>   |                                  | <b>HYATTSVILLE</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Sept 5, 1967</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland Pro Geo Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>F. Gasch's Sons</b>   |                                  | ADDRESS<br><b>Hyattsville, Md.</b>  |   |
| 25a. REC'D BY REGISTRAR<br><b>SEP 8 1967</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

MASTERS OF THE VESSEL TO BE IN THE  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12916

12925

|  |                                  |   |  |   |   |   |   |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>D.C.</b> b. COUNTY         |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (rural)</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>673 days</b>                             |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Glenn Dale Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>D.C. Village</b>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Madison</b> Middle Last <b>Smith</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>28</b> Year <b>1967</b>   |   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-26-1908</b>                                  |   | 9. AGE (In years last birthday)<br><b>58</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bell Hop</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>North Carolina</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Frank Smith</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mattie S. Hilliard</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes 1944-45</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>244-12-4005</b>   |  | 17. INFORMANT<br><b>Decedent</b> Address  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cerebral arteriosclerosis</b><br>DUE TO (c) <b>generalized arteriosclerosis</b> |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Pulmonary tuberculosis, minimal;</b>  |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)              |   |   |
| 21. I certify that <del>no</del> (this hospital) attended the deceased from <b>11/24 1965</b> to <b>9/28 1967</b> , that <del>we</del> (we) last saw the deceased alive on <b>9/28 1967</b> , and that death occurred at <b>12:35 A</b> , from causes and on the date stated above.  |                                  |   |  |   |   |   |   |
| 22a. SIGNATURE<br><i>Moe Weiss</i>   |                                  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>9/28/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Moe Weiss M.D.</b>  |                                  |   |  | 22d. ADDRESS<br><b>Glenn Dale Hospital<br/>Glenn Dale, Maryland</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                                  | 23b. DATE THEREOF<br><b>Oct. 4, 67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Mem. Park</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Lanover, Maryland P.G.Cty</b>                     |   |
| 24. FUNERAL DIRECTOR<br><b>PETWORTH</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><b>OCT 4 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

D.C.

Private Property

Washington

673 days

Glenn Dale (rural)

U.S. Village

Glenn Dale Hospital

September 18 51

Smith

Madden

10-26-1908

Maine

Bell Hop

North Carolina

Frank Smith

Marion E. Williams

Occupant

100-12-6002

Yes 1944-45

Records not maintained in accordance with

original records of the

U.S. Department of Justice

U.S. Department of Justice

9128

11120

9128

9128

Glenn Dale Hospital  
Glenn Dale, Maryland

Howe House H.D.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12917

12927

|   |                                  |   |  |   |   |   |   |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>                      |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                  |   | c. LENGTH OF STAY IN lb<br><b>DOA</b>                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CLINTON</b>  |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>8100 VISMINOMA</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thelma</b> Middle <b>Elizabeth</b> Last <b>Steele</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>8</b> Year <b>19 67</b>   |   |   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-5-23</b>                                      | 9. AGE (In years last birthday) yrs.<br><b>44</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>FURMER H. FRADY</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY ALICE CLOWERS</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>235-38-2456</b>   |  | 17. INFORMANT Address<br><b>Arvil Steele Husband Princeton, W. Va.</b>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sub-arachnoid hemorrhage</b><br><b>330X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)                               |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)      |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |   |   |
| ACTUAL SIGNATURE<br><b>John Kehoe</b>   |                                  | M.D.<br><b>John Kehoe M.D., Riverdale, Maryland</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22. DATE SIGNED<br><b>9-9-67</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9/12/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pettrey</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Pettrey Mercer W. Va.</b>                               |   |
| 24. FUNERAL DIRECTOR<br><b>GASCH'S</b>  |                                  |   |  | ADDRESS<br><b>HYATTSVILLE, MARYLAND</b>   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 11 1967</b><br>DATE<br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12928

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>   |  |
| c. LENGTH OF STAY IN 1b <b>DOA</b>   |   | d. STREET ADDRESS <b>7421 Finns Lane</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>C</b> Last <b>Strailman</b>  |   | 4. DATE OF DEATH<br>Month <b>9</b> Day <b>14</b> Year <b>19 67</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>21 March 1900</b>                                      |
| 9. AGE (In years last birthday) <b>67</b> yrs.   |   | 10. IF UNDER 1 YEAR Months Days  | 11. IF UNDER 24 HRS. Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Wood Yard</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Unknown</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>   |   | 16. SOCIAL SECURITY NO. <b>579-09-8549</b>   |  |
| 17. INFORMANT <b>Rose Marie Nalley</b>   |   | Address <b>Same As # 2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>DUE TO <b>Arteriosclerotic heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>over 1 yr.</b>       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>               |   |  |  |
| ACTUAL SIGNATURE <b>John Kehoe</b> M.D.  |   | 22. DATE SIGNED <b>9-14-67</b>   |  |
| EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>  |   | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>9/18/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>   | 23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Maryland</b> |
| 24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc.</b>   |   | 25a. REC'D BY REGISTRAR <b>SEP 18 1967</b>   |  |
| Address <b>517 11th St. S.E. Washington, D.C.</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

1

12  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12913

12929

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Pro Geo County</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>PG.</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverry</b>   |  | c. LENGTH OF STAY IN 1b  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pro. Geo. Hospital</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Lanham</b>  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | d. STREET ADDRESS <b>7731 Emerson Rd</b>   |  |
| 3. NAME OF DECEASED (Type or print) <b>John</b> First <b>G</b> Middle <b>Sturm</b> Last <b>Sr.</b>   |  | 4. DATE OF DEATH <b>9</b> Month <b>18</b> Year <b>1967</b>   |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Oct 24, 1915</b>                             |
| 9. AGE (In years last birthday) <b>51</b> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>New Port News Va</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>Henry J. Sturm</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Gertrude De'Sales Maloney</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  | 16. SOCIAL SECURITY NO. <b>226 05 6386</b>   |  |
| 17. INFORMANT <b>Adele Sturm</b>   |  | Address <b>West Lanham Hills, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute renal failure</b><br>DUE TO <b>5810</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Liver cirrhosis, nutritional, severe.</b><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH <b>One week</b><br><b>Two years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonitis + chronic bronchitis</b>  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                             |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/7</b> , 19 <b>67</b> , to <b>9/18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9-18 - 1967</b> , and that death occurred at <b>9:18 P.M.</b> from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE <b>R. U. FRANCHI</b>  |  | 22b. DATE SIGNED <b>9/19/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>R. U. FRANCHI, MD</b>  |  | 22d. ADDRESS <b>7729 Finn's Lane, Lanham, Md</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>Sept. 21, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State) <b>Hampton Va.</b> |
| 24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>  |  | 25a. REC'D BY REGISTRAR <b>SEP 21 1967</b>   |  |
| ADDRESS <b>Hyattsville, Md.</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

West London  
1731 Emswary Rd

18 01  
P  
V.R.V.

Acute renal failure  
Liver congested, nutritional, severe

Pneumonia + chronic bronchitis

9/18 01  
9/17 01  
9/16 01  
9/15 01  
9/14 01  
9/13 01  
9/12 01  
9/11 01  
9/10 01  
9/9 01  
9/8 01  
9/7 01  
9/6 01  
9/5 01  
9/4 01  
9/3 01  
9/2 01  
9/1 01

9-18-01  
Total number  
R.M. FRANCHI, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                   |   |   |  |  |  |  |  |
|---|--|-----------------------------------|---|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                   |   |   |  |  |  |  |  |
| 12920   |  |                                   |   |   | 12930  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND   |  |                                   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Prince George |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hyattsville   |  |                                   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Hyattsville                                    |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>5821 33rd Place   |  |                                   |   |   | d. STREET ADDRESS<br>5821 33rd Place   |  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                   |   |   |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>John A. Tarakus   |  |                                   | 4. DATE OF DEATH<br>Month Day Year<br>September 7, 1967 |   |  |  |  |  |  |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>White         |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Dec 18, 1897                                       |  | 9. AGE (In years last birthday)<br>69 yrs.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Draftsman  |  | 10b. KIND OF BUSINESS OR INDUSTRY |   | 11. BIRTHPLACE (County & State, or foreign country)<br>Estonia  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |  |
| 13. FATHER'S NAME<br>Andrew Tarakus   |  |                                   |   | 14. MOTHER'S MAIDEN NAME<br>Barbara Aleksur   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |  |                                   |   | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Isidora Tarakus Same as # 2                           |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 2044<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c) |  |                                   |   | Leucemia.   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>immediate.                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                                   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |                                   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that (I) (this hospital) attended the deceased from May, 1966, to September 7, 1967, that (I) (we) last saw the deceased alive on September 7, 1967, and that death occurred at 11:28 A.M. from the causes and on the date stated above.              |  |                                   |   |   |  |  |  |  |  |
| 22a. SIGNATURE<br>Leonhard J. Hantsoo M.D.  |  |                                   |   | 22b. DATE SIGNED<br>Sept. 7, 1967.  |  | 22c. PHYSICIAN'S NAME (Type) LEONHARD J. HANTSOO, M.D.                 |  |  |  |
| 22d. ADDRESS<br>701 MARYLAND AVENUE, N.E. Wash. D.C.  |  |                                   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Transport  |  |                                   |   | 23b. DATE THEREOF<br>9-7-1967   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Recoleta                         |  | 23d. LOCATION (City, town or county) (State)<br>Recoleta, Paraguay |  |
| 24. FUNERAL DIRECTOR<br>Robert A. Mattingly   |  |                                   |   | ADDRESS<br>1311 1/2 St. N.E. Wash. D.C.   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 8 1967                             |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                        |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12921

## CERTIFICATE OF DEATH

12931

|  |  |  |   |   |   |  |  |
|--|--|--|---|---|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesent</u><br>c. LENGTH OF STAY IN 1b <u>18 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5709 LANDOVER RD</u>        |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission)<br>e. STATE <u>md</u> <span style="float: right;">b. COUNTY <u>Prince Georges</u></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesent</u><br>d. STREET ADDRESS <u>5709 LANDOVER RD</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>GLADYS MARY TIPTON</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>Sept</u> Day <u>8</u> Year <u>1967</u>   |   |   |   |  |  |
| <b>5. SEX</b><br><u>F</u>  | <b>6. COLOR OR RACE</b><br><u>W</u>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>3/16/01</u>                   | <b>9. AGE</b> (In years last birthday) <u>66</u> yrs.<br>IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u><br>IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>   |   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>INDIANA</u>   |   |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |  |  |   |   |   |  |  |
| <b>13. FATHER'S NAME</b><br><u>Henry Vaughn</u>  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Theresa May Davis</u> |   |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b>   |   | <b>17. INFORMANT</b><br><u>daughter</u>   |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>4201</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive (Arterio Vascular) Disease 20 yrs</u><br>(e), stating the underlying cause last. DUE TO (c) |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>72 hrs</u> |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |   |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |   |   |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour e.m. <u>19</u><br>p.m.  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  | <b>20f. (City or town)</b>                                  | <b>(County)</b>   | <b>(State)</b>                                    |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1955</u> <b>to</b> <u>9/8/67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>9/8/67</u> , <b>and that death occurred at</b> <u>9:30 AM</u> , <b>from the causes and on the date stated above.</b>  |  |  |   |   |   |  |  |
| <b>22a. SIGNATURE</b><br><u>Norman D. Comreau</u> M.D.   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>               |   | <b>22b. DATE SIGNED</b><br><u>9/8/67</u>  |   |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Norman D. Comreau</u>  |  | <b>22d. ADDRESS</b><br><u>3503 PEARLY ST MT RAINIER MD</u>   |   |   |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>Sept 11, 1967</u>   |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Whitfield Cemetery</u>  |   |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br><u>Lanham Pro Georges</u>   |  | <b>(State)</b><br><u>Md.</u>   |   |   |   |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>F. Gasch's Sons</u>  |  | <b>ADDRESS</b><br><u>Hyattsville, Md.</u>  |   | <b>25a. REC'D BY REGISTRAR</b><br><u>SEP 11 1967</u>  |   |  |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>  |  |  |   |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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SEP 14 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |                   |   |  |   |  |  |   |  |  |
|---|--|---------------------------|-------------------|---|--|---|--|--|---|--|--|
| 12922   |  |                           |                   |   |  | 12932   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Prince's George's MARYLAND   |  |                           |                   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE D.C. b. COUNTY          |  |  |   |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Clinton, Md.  |  |                           |                   | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Washington, 47-3                      |  |  |   | d. STREET ADDRESS<br>1344-Mapleview Pl. S.E.   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Pine View Gardens   |  |                           |                   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |  |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print) Frederick W. Traband, Sr.  |  |                           | First Middle Last |   |  | 4. DATE OF DEATH<br>9 24 19 67  |  |  | Month Day Year  |  |  |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>white |                   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>3-16-1886   |  | 9. AGE (in years last birthday)<br>81 yrs. |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Machinist  |  |                           |                   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Prince Geo. Co. Md.  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                        |  |  |
| 13. FATHER'S NAME<br>Charles Traband  |  |                           |                   |   |  | 14. MOTHER'S MAIDEN NAME<br>Priscilla Dove  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  |                           |                   | 16. SOCIAL SECURITY NO.<br>579-60-5642  |  | 17. INFORMANT 6431 Shadyside Lane Falls Ch. Va.<br>Frederick Traband, Jr. son   |  |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 177X Congestive Heart Failure<br>DUE TO (b) Pulmonary Circulatory collapse<br>DUE TO (c) Ca of Prostate.<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                           |                   |   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>3-4 days   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                           |                   |   |  |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                           |                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |                           |                   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)       |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21. I certify that (I) (this hospital) attended the deceased from 8-11, 19 67, to 9-24, 19 67, that (I) (we) last saw the deceased alive on 9-24, 19 67, and that death occurred at 11:00 M, from the causes and on the date stated above.  |  |                           |                   |   |  |   |  |  |   |  |  |
| 22a. SIGNATURE<br>Alfred R. Lapin   |  |                           |                   |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22b. DATE SIGNED  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>ALFRED R. LAPIN, MD   |  |                           |                   |   |  | 22d. ADDRESS  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |                           |                   | 23b. DATE THEREOF<br>9-27-67  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |  |  | 23d. LOCATION (City, town or county) (State)<br>Suitland, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>Lee Funeral Home 300-4th St. N.E. Wash. D.C.  |  |                           |                   |   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 27 1967   |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                   |  |  |

(M)

SEP 21 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12923

CERTIFICATE OF DEATH

12933

|  |                                  |   |  |   |  |   |   |
|--|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Prince Georges</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>11 days</b>  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Colmar Manor</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>3403 42nd Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>George W. Trainum jr</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 6, 19 67</b>   |  |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>11/15/12</b>  |   | 9. AGE (In years last birthday)<br><b>54</b> yrs.                      | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Vice Pres Richard England Assoc</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Virginia</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>U S A.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A.</b> |
| 13. FATHER'S NAME<br><b>George W. Trainum sr</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bessie Snead</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>578-05-9268</b>   |  | 17. INFORMANT<br>Address<br><b>Doris T. Trainum 3403.42nd ave</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Failure</b><br>5810 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastrointestinal hemorrhage</b><br>DUE TO (c) <b>Cirrhosis of the liver</b> |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>many years</b>                                  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)          |
| 21. I certify that (I) (the <del>physician</del> ) attended the deceased from <b>4/26</b> , 19 <b>67</b> , to <b>Sept. 6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Sept. 6</b> , 19 <b>67</b> , and that death occurred at <b>6:30 P</b> M, from causes and on the date stated above.   |                                  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><b>Frederick H. Wilhelm MD</b>   |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                         |  | 22b. DATE SIGNED<br><b>Sept 7, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Frederick H. Wilhelm, M. D.</b>   |                                  |   |  | 22d. ADDRESS<br><b>6319 Landover Rd. Cheverly, Maryland</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>9.11.1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Colmar Manor Maryland</b>                           |   |
| 24. FUNERAL DIRECTOR<br><b>Lee Funeral Home. 300.4th st N E</b>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 11 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>g. Charles Judge</b>   |   |

1943

STATEMENT OF DEATH

Place of death

State

Place of death

Place of death

State

Place of death

Place of death

Place of death

Place of death

State

Place of death

State

Place of death

State

U.S.A.

Virginia

Vice President of the United States

George W. Bush

George W. Bush

George W. Bush

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |  |  |  |   |  |  |  |  |  |                                  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|----------------------------------|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <i>Prince George</i> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Laurel</i><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Laurel General Hosp.</i>   |  |  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Md</i> b. COUNTY <i>Pr. Geo</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i><br>d. STREET ADDRESS <i>39 Anandale St.</i><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <i>Cecilia Ann Trigger</i><br>First Middle Last<br><b>5. SEX</b> <i>F</i> <b>6. COLOR OR RACE</b> <i>W</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>Dec 31, 1904</i><br><b>9. AGE</b> (In years last birthday) <i>62</i> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min. |  |  |  |  |  | <b>4. DATE OF DEATH</b> <i>Sept 4</i> Month Day Year <i>1967</i><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housewife</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>home</i> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Port Vire Penn.</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>               |  |  |  |  |  |                                  |  |
| <b>13. FATHER'S NAME</b> <i>Joseph Henry Venneshush</i><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>   |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b> <i>Budget Gil</i><br><b>16. SOCIAL SECURITY NO.</b> <i>James A. Trigger, Laurel Md</i><br><b>17. INFORMANT</b> Address  |  |  |  |  |  |                                  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Kidney failure, uremia</i><br>DUE TO (b) <i>Diabetes, arteriosclerosis, stroke</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>same</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                |  |  |  |  |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |  |  |  |  |                                  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <i>19</i>   |  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)                          |  |  |  |                                  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>1959</i> to <i>9-4</i> , 1967, that (I) (we) last saw the deceased alive on <i>9-3</i> , 1967, and that death occurred at <i>8:50 A.M.</i> from the causes and on the date stated above.  |  |  |  |  |  |   |  |  |  |  |  |                                  |  |
| <b>22a. SIGNATURE</b> <i>Isidoro Pierandrei's</i> M.D.<br><b>22c. PHYSICIAN'S NAME</b> (Type)   |  |  |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/><br><b>22d. ADDRESS</b> <i>9-4-67</i><br><b>22b. DATE SIGNED</b>  |  |  |  |  |  |                                  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>  |  |  |  | <b>23b. DATE THEREOF</b> <i>9/6/67</i>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Sanage Cem</i>   |  | <b>23d. LOCATION</b> (City, town or county) (State) <i>Sanage Md</i> |  |  |  |                                  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>de Witt Carvelson, Laurel, Md</i> ADDRESS  |  |  |  |  |  | <b>25a. REC'D BY REGISTRAR</b> <i>SEP 11 1967</i> <b>25b. REGISTRAR'S SIGNATURE</b> <i>James J. J...</i>  |  |  |  |  |  |                                  |  |

1898

CERTIFICATE OF DEBIT

1898

*[Faint, illegible handwriting throughout the main body of the document, likely representing a ledger or account record.]*

22

*[Faint, illegible handwriting at the bottom of the page, possibly a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>737</div> <div>738</div> <div>739</div> <div>740</div> <div>741</div> <div>742</div> <div>743</div> <div>744</div> <div>745</div> <div>746</div> <div>747</div> <div>748</div> <div>749</div> <div>750</div> <div>751</div> <div>752</div> <div>753</div> <div>754</div> <div>755</div> <div>756</div> <div>757</div> <div>758</div> <div>759</div> <div>760</div> <div>761</div> <div>762</div> <div>763</div> <div>764</div> <div>765</div> <div>766</div> <div>767</div> <div>768</div> <div>769</div> <div>770</div> <div>771</div> <div>772</div> <div>773</div> <div>774</div> <div>775</div> <div>776</div> <div>777</div> <div>778</div> <div>779</div> <div>780</div> <div>781</div> <div>782</div> <div>783</div> <div>784</div> <div>785</div> <div>786</div> <div>787</div> <div>788</div> <div>789</div> <div>790</div> <div>791</div> <div>792</div> <div>793</div> <div>794</div> <div>795</div> <div>796</div> <div>797</div> <div>798</div> <div>799</div> <div>800</div> <div>801</div> <div>802</div> <div>803</div> <div>804</div> <div>805</div> <div>806</div> <div>807</div> <div>808</div> <div>809</div> <div>810</div> <div>811</div> <div>812</div> <div>813</div> <div>814</div> <div>815</div> <div>816</div> <div>817</div> <div>818</div> <div>819</div> <div>820</div> <div>821</div> <div>822</div> <div>823</div> <div>824</div> <div>825</div> <div>826</div> <div>827</div> <div>828</div> <div>829</div> <div>830</div> <div>831</div> <div>832</div> <div>833</div> <div>834</div> <div>835</div> <div>836</div> <div>837</div> <div>838</div> <div>839</div> <div>840</div> <div>841</div> <div>842</div> <div>843</div> <div>844</div> <div>845</div> <div>846</div> <div>847</div> <div>848</div> <div>849</div> <div>850</div> <div>851</div> <div>852</div> <div>853</div> <div>854</div> <div>855</div> <div>856</div> <div>857</div> <div>858</div> <div>859</div> <div>860</div> <div>861</div> <div>862</div> <div>863</div> <div>864</div> <div>865</div> <div>866</div> <div>867</div> <div>868</div> 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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>  |  |  |  |  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>                   |  |  |  |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Camp Springs</b>   |  |  |  |  |  |  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Camp Springs</b>  |  |  |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>6103 Old Branch Avenue</b>   |  |  |  |  |  |  |  |  |  | d. STREET ADDRESS<br><b>6103 Old Branch Avenue</b>   |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cora</b> Middle <b>R.</b> Last <b>Trueman</b>   |  |  |  |  |  |  |  |  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>13</b> Year <b>1967</b>  |  |  |  |  |  |  |  |  |  |
| 5. SEX <b>Female</b>  |  |  |  |  |  |  |  |  |  | 6. COLOR OR RACE <b>White</b>  |  |  |  |  |  |  |  |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 8. DATE OF BIRTH<br><b>July 13, 1887</b>   |  |  |  |  |  |  |  |  |  |
| 9. AGE (In years last birthday) <b>80</b> yrs.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  |  |  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |  |  |  |  |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ma ryland</b>   |  |  |  |  |  |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Henry W. Grimes</b>   |  |  |  |  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Hyde</b>  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  |  |  |  |  |  |  |  | 16. SOCIAL SECURITY NO. <b>-----</b>   |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT<br><b>Guy H. Trueman-Same as Item #2.</b>   |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br>593X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Congestive Heart failure</b><br>(c) <b>Kidney disease</b><br>DUE TO<br>causa last.  |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2-3 days</b><br><b>2 weeks</b><br><b>1 1/2 yrs</b>  |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |  |  |  |  |  |  |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  |  |  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 1965</b> to <b>September 13, 1967</b> that (I) (we) last saw the deceased alive on <b>Sept 13, 1967</b> , and that death occurred at <b>9:20 P.M.</b> from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>David N. Robb</b> M.D.   |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED<br><b>9/13/67</b>   |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>David N. Robb, M. D.</b>   |  |  |  |  |  |  |  |  |  | 22d. ADDRESS<br><b>5116 Middleton Lane, Camp Springs, Md.</b>  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE THEREOF<br><b>9/16/67</b>  |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Barnabas Cemetery</b>  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Oxon Hill, Maryland</b>   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ritchie Bros. Upper Marlboro, Md.</b>  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>OCT 11 1967</b>  |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Ritchie Bros. Upper Marlboro, Md.

9/15/57

St. Barnabas Cemetery, Green Hill, Maryland

David M. Jones, Green Hill, Md.

9/15/57

No

Henry W. Grimes

Own home

Ma. Hill

U. S. A.

Female

White

X

W.

Town

July 13, 1887

60

September 13, 57

6103 Old Branch Avenue

6103 Old Branch Avenue

Life

Camp Springs

Prince Georges

Maryland

Pr. Geo's

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12926 CERTIFICATE OF DEATH 12935

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>e. COUNTY <u>Prince Geo.</u> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>MD.</u> b. COUNTY <u>P.G.</u>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CHEVERLY</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>COLLEGE OXON HILL 161</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Prince Geo. Gen. Hospital.</u>  |   | d. STREET ADDRESS<br><u>6407 WILMETTER DR.</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>MARGARET MARY TRUEMAN</u>  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>SEPT 3 1967</u>   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>5-18-85</u>           |
| 9. AGE (In years last birthday)<br><u>82</u> yrs.  |   | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>DOMESTIC</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>CHARLES MD.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>JOSEPH WATERS</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>ELLEN S. DAVIS</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>NO</u>   |   | 16. SOCIAL SECURITY NO.<br><u>6407 WILMETTE DRIVE</u>  |  |
| 17. INFORMANT<br><u>MARY TEVAULT, OXON HILL, MD</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL ARTERIOSCLEROSIS</u><br>(a), stating the underlying cause last. (c) <u>ESSENTIAL HYPERTENSION</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>ESSENTIAL HYPERTENSION</u> |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 MONTH</u><br><u>10 yrs</u>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)         |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above. |   |  |  |
| 22a. SIGNATURE<br><u>Roger B. Ingham MD</u>  |   | 22b. DATE SIGNED<br><u>9-3-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ROGER B. INGHAM</u>   |   | 22d. ADDRESS<br><u>P.G. GENERAL HOSP.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City, town or county) (State) |
| <u>BURIAL</u>  | <u>9-6-67</u>   | <u>ST PAULS CEM.</u>   | <u>BADEN P.G., MD.</u>                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>THE HUNTT FUNERAL HOME, WALDORF, MD.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 11 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. J...</u>   |   |  |  |



1. The first part of the document is a list of names and dates, which appears to be a roster or a list of events. The names are written in a cursive script, and the dates are in a standard font. The list is organized into two columns, with names on the left and dates on the right.

4-240797H JAN 20 1973

Robert B. Johnson  
Rogers & Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12927

CERTIFICATE OF DEATH

12936

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>  |  | d. STREET ADDRESS<br><b>220 Edgevale Road</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Gladys</b> Middle <b>Urps</b> Last <b>Sept.</b>  |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>19</b> Year <b>67</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Cauc.</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 11, 1906</b>   |
| 9. AGE (In years last birthday)<br><b>61</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>19</b> Hours <b>67</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Chilhowie, Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Matthew Berry</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Virginia Trent</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>----</b>  |  |
| 17. INFORMANT<br><b>Charles Urps - same</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>4201</b><br>DUE TO <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <b>Hypertensive Vascular Disease</b><br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9-3</b> , 19 <b>67</b> , to <b>9-3</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>9-3</b> , 19 <b>67</b> , and that death occurred at <b>7:15AM</b> , from causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE<br><b>Rafael C. Lee</b>   |  | 22b. DATE SIGNED<br><b>9-3-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Rafael C. Lee</b>   |  | 22d. ADDRESS<br><b>Prince Georges Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Sept. 6, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Ritchie Hwy., A.A.Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce - 4001 Ritchie Hwy., Baltimore</b>  |  | 25a. REC'D BY REGISTRAR<br><b>SEP 8 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Gonce</b>  |  |   |  |





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1  
9  
9

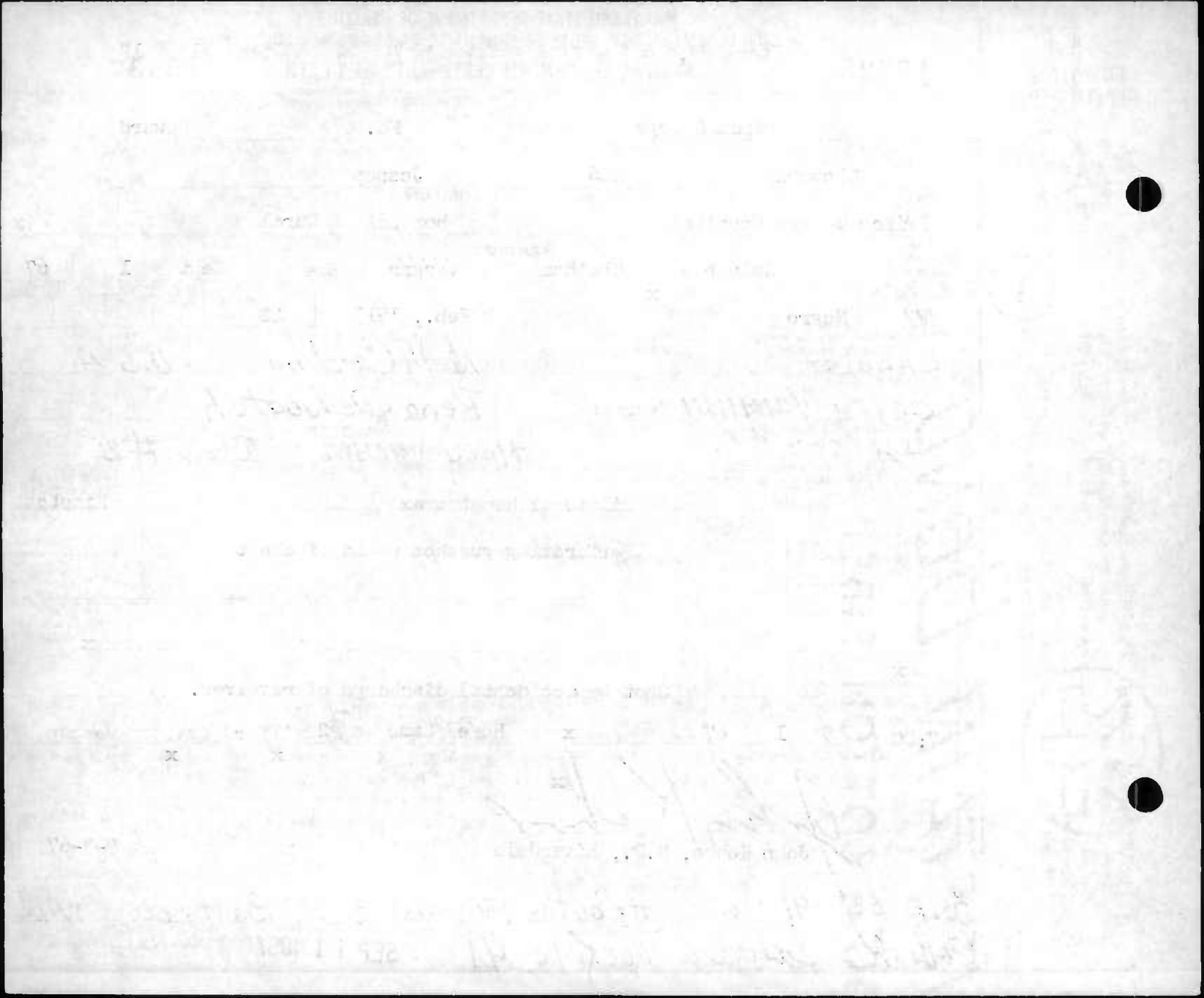
12928

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #3, 5 & 20e Film #G393 9/27/67 oh & Items #13 & 17

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12937

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY Prince George MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE Md. b. COUNTY Howard   |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Cheverly  |  |   |  | c. LENGTH OF STAY IN 1b<br>DOA   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Prince George Hospital  |  |   |  | d. STREET ADDRESS<br>Box 86A Rural   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Columbus Chetham Vaughn   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br>Sept 1 19 67   |  |   |   |
| 5. SEX Male   |  | 6. COLOR OR RACE Negro                    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br>2 Feb., 1919  |   |
| 9. AGE (In years last birthday)<br>48 yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |
| 11. BIRTHPLACE (State or foreign country)<br>North Carolina   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |
| 13. FATHER'S NAME<br>Berry VAUGHN   |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Rena DeLoatch  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Vaughn<br>Mary VAUGHN Item #2  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Bilateral hemothorax<br>9190<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Perforating gunshot wound of chest<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>Minutes   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Shot by accidental discharge of revolver.  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>7:00 pm 9 1 19 67  |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>of work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br>Box 83<br>Home / Same as #2 Guilford Ave. Jessup Md. |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>               |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>John Kehoe, M.D., Riverdale   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |  |   |   |
| 22. DATE SIGNED<br>9-3-67   |  |   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF                         |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |   |
| Burial  |  | 9/7/67                                    |  | Arbutus Memorial Cem.  |  | Baltimore Md.   |   |
| 24. FUNERAL DIRECTOR<br>Robert L. Suroudeu  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 11 1967  |  |   |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...  |  |   |   |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12923

**CERTIFICATE OF DEATH**

12938

|  |                                  |   |                                       |  |   |   |                                |
|--|----------------------------------|---|---------------------------------------|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <u>PRINCE GEORGE CO, MD</u><br>MARYLAND   |                                  |   |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>PG COUNTY</u> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>NEW CARROLTON</u>   |                                  | c. LENGTH OF STAY IN lb<br><u>3-4 yrs</u>   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>NEW CARROLTON, MD</u>                                 |   |   |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>7308 LONGBRANCH DRIVE</u>   |                                  |   |                                       | d. STREET ADDRESS<br><u>7308 LONGBRANCH DR</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF DECEASED (Type or print)<br><u>MRS ELLA H. D. WHEELER</u>   |                                  |   |                                       | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>18,</u> Year <u>19 67</u>  |   |   |                                |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>CAUS.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug 3 1976</u> | 9. AGE (In years lost birthday) yrs.<br><u>91</u>  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>   |                                       | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Danville, Penna.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                |
| 13. FATHER'S NAME<br><u>Henry Joseph Diver</u>   |                                  |   |                                       | 14. MOTHER'S MAIDEN NAME<br><u>Barbara Fleckenstein</u>  |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>196-10-574</u>  |                                       | 17. INFORMANT<br><u>Walter Walter</u> Address <u>7308 Long Branch Dr, New Carrollton, MD</u>   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia and probable embolus</u><br><u>332X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral atherosclerosis</u><br>DUE TO (c) <u>Diffuse atherosclerotic disease</u> |                                  |   |                                       |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>years</u><br><u>years</u>                                  |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u></u>   |                                  |   |                                       |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |  |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> o.m. p.m.   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>18</u> to <u>18 Sept 67</u> , that (I) (we) lost the deceased alive on <u>2 Sept 1967</u> and that death occurred at <u>12 PM</u> , from causes and on the date stated above.  |                                  |   |                                       |  |   |   |                                |
| 22a. SIGNATURE<br><u>James W. Harding, Jr.</u>   |                                  | 22b. DATES SIGNED<br><u>18 Sept 67</u>  |                                       | 22c. PHYSICIAN'S NAME (Type)<br><u>James W. Harding, Jr.</u>   |   | 22d. ADDRESS<br><u>7601 Riverdale Road Hyattsville, Maryland</u>                                  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 23b. DATE THEREOF<br><u>9-23-67</u>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ODD Fellow Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Danville Penna</u>                            |                                |
| 24. FUNERAL DIRECTOR<br><u>Robert A. Humphrey</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>SEP 22 1967</u>   |                                       | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | 25c. ADDRESS<br><u>7551 Wisc Ave Bethesda, MD</u>   |                                |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-28

CERTIFICATE OF DEATH

1942

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

10-28

1942

10-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

10/19/67  
A54

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12930

Item #9 Film #G392 9/20/67 ph

CERTIFICATE OF DEATH

12939

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Prince Georges</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b><br>c. LENGTH OF STAY IN 1b<br><b>44 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince Georges General Hospital</b>   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Prince Georges</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Seat Pleasant</b><br>d. STREET ADDRESS<br><b>7282 George Palmer Highway</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Cora T. Wilburne</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 4, 1967</b>   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/23/06</b>   | 9. AGE (In years last birthday)<br><b>61 39/ yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>16 1</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WASH. TERMINAL</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>                              |   |
| 13. FATHER'S NAME<br><b>George MARSHALL Thomas</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mildred Selby</b>   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>MRS. OLIVIA GROSS - Sister Lane, Beltsville</b><br>Address <b>10622 - Cross</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>4201</b><br>DUE TO<br><b>Acute myocardial infarction; secondary to</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Occlusive coronary arteriosclerosis.</b><br>DUE TO<br>(c)<br><b>Conjunctive heart disease cardiomegaly (600 grms.)</b> |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County)  | (State)   |
| 21. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>July 22, 1967</b> , to <b>Sept. 4, 1967</b> , that <del>(s)</del> (we) last saw the deceased alive on <b>Sept. 4, 1967</b> , and that death occurred at <b>5:50 AM</b> from causes and on the date stated above.  |  |   |  |   |   |
| 22a. SIGNATURE<br><b>A. Clark Holmes</b>  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                     |  | 22b. DATE SIGNED<br><b>9/5/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. Clark Holmes, M. D.</b>   |  | 22d. ADDRESS<br><b>Prince Georges General Hospital</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>9-9-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sandy Springs Cem.</b>   | 23d. LOCATION (City or Town)   | (County)  | (State)<br><b>Md</b>  |
| 24. FUNERAL DIRECTOR<br><b>Henry D. Washington &amp; Sons Inc.</b><br><b>4925 Gleane Ave. N.E. Wash. D.C.</b>   |  |   | 25a. REC'D BY REGISTRAR<br><b>SEP 7 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

Prison George

Mar 1909

East Prison

of have

1202 George - East Prison

Prison George - East Prison

57

Prison

Prison

Prison

Prison

Prison

Prison

Acute myocardial infarction; see below to

Definitive coronary atherosclerosis.

Coronary heart disease (500 years).

July 25, 1907

5:30 PM

2001 A. 57

Prison George - East Prison

A. Clark, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12931

CERTIFICATE OF DEATH

12940

|   |                                    |   |  |  |   |
|---|------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince George's</b> MARYLAND  |                                    |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cheverly</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>12 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Seat Pleasant</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Prince George's General Hospital</b>   |                                    |   | d. STREET ADDRESS<br><b>7210 F Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Howard</b> Middle <b>W.</b> Last <b>Williams</b>  |                                    |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>9</b> Year <b>1967</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/18/89</b>  | 9. AGE (In years last birthday)<br><b>77</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retiree</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Married</b>                                    |   |
| 13. FATHER'S NAME<br><b>Henry Williams</b>  |                                    |   | 14. MOTHER'S MAIDEN NAME<br><b>Ellen (unknown)</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |                                    | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mrs. Ellen Smith-7210 F St</b> Address <b>Seat Pleasant Maryland</b>                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4221 Uremia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease.</b><br>DUE TO (c) |                                    |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>2. Cerebral thrombosis</b>  |                                    |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>August 28</b> , 19 <b>67</b> , to <b>Sept. 9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Sept. 9</b> , 19 <b>67</b> , and that death occurred at <b>6:05A</b> M, from causes and on the date stated above.                          |                                    |   |  |  |   |
| 22a. SIGNATURE<br><b>A. Clark Holmes</b>  |                                    |   | 22b. DATE SIGNED<br><b>9/9/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>A. Clark Holmes, M.D.</b>                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 23b. DATE THEREOF<br><b>9/13/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Stewart Funeral Home</b>   |                                    |   | 25a. REC'D BY REGISTRAR<br><b>SEP 13 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

CERTIFICATE OF DEATH

John George  
12 years  
Latter George's General Hospital  
7110 E Street  
William Howard  
December 8, 1971

Wife Colored 77

Native  
Henry  
10/18/1903  
12

Age 67  
Date of Death  
Cause of Death

A. Clark Holmes, M.D.  
1108 Evans St., South Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

M

12932

12941

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Georges</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>D. C.</b><br>b. COUNTY                                 |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glenn Dale (rural)</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |                                     |
| c. LENGTH OF STAY IN 1b<br><b>4 mos.</b>  |                                  | 47-3  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Glenn Dale Hospital</b>  |                                  | d. STREET ADDRESS<br><b>917 47th St., N. E.</b>   |                                     |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Leroy</b> Middle <b>--</b> Last <b>Wright</b>  |                                  | 4. DATE OF DEATH<br>Month <b>9/</b> Day <b>24/</b> Year <b>1967</b>   |                                     |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/5/1914</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>53</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>truck driver</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b>   |                                     |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>N. C.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                     |
| 13. FATHER'S NAME<br><b>Hurt Wright</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Nancy Holmes</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>216-20-6168</b>   |                                     |
| 17. INFORMANT<br><b>Decedent</b>  |                                  | Address   |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent cerebrovascular accident</b><br>331X<br>DUE TO<br>(b) _____<br>DUE TO<br>(c) <b>Generalized arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |                                     |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>unknown</b>   |                                  |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Hypertensive and arteriosclerotic cardiovascular disease</b>   |                                  |   |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/24/</b> , 1967, to <b>9/24/</b> , 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/24/</b> , 1967, and that death occurred at <b>11 AM</b> , from causes and on the date stated above.                             |                                  |   |                                     |
| 22a. SIGNATURE<br><b>Moe Weiss</b>  |                                  | 22b. DATE SIGNED<br><b>9/24/67</b>  |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Moe Weiss, M. D.</b>   |                                  | 22d. ADDRESS<br><b>Glenn Dale Hospital<br/>Glenn Dale, Md.</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE THEREOF<br><b>9-29-67</b>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Park</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Landover Md</b>   |                                     |
| 24. FUNERAL DIRECTOR<br><b>Rollins 4339/Hurt P. H. E.</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 27 1967</b>  |                                     |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                  |   |                                     |

STATEMENT OF CASE

George George

D. O.

Washington

A. M. S.

Glenn Dale Hospital

Glenn Dale Hospital

915 4th St., N. E.

Male Negro  
Age 33  
Date of Birth 5/5/1914  
Place of Birth Washington, D. C.  
Country of Birth USA

Henry Holmes

Glenn Dale Hospital

210-22-2300  
Washington

Presented a request for admission

Examination and treatment of the patient  
Generalized anxiety disorder

Glenn Dale Hospital  
Washington, D. C.  
Date of Admission 5/15/54  
Date of Discharge 5/21/54  
Referral by Dr. [illegible]  
Referral to Dr. [illegible]

Glenn Dale Hospital  
Washington, D. C.

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4 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12933

CERTIFICATE OF DEATH

12942

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>In Geo</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Ind</i> b. COUNTY <i>On Geo</i>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Lanham</i>   |   | c. LENGTH OF STAY IN 1b<br><i>3 yr</i>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>College Park, Md</i> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Wagnolia Gardens Nursing Home</i>  |   | d. STREET ADDRESS<br><i>7306 YALE AVE</i>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |
| 3. NAME OF DECEASED<br>(Type or print)<br><i>Louise</i>   |   | First <i>Louise</i> Middle <i>SALES</i> Last <i>SALES</i>   | 4. DATE OF DEATH<br>Month <i>Sept</i> Day <i>14</i> Year <i>1967</i>  |
| 5. SEX<br><i>F</i>  | 6. COLOR OR RACE<br><i>W</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>June 21, 1873</i>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Supervisor</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i>  | 9. AGE (In years last birthday)<br><i>94</i> yrs.   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Czechoslovakia</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 13. FATHER'S NAME<br><i>unknown</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>unknown</i>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |   | 16. SOCIAL SECURITY NO.<br><i>220 09 0915A</i>  |   |
| 17. INFORMANT<br><i>Emanuel L. Zalesak</i>  |   | Address <i>College Park Md</i>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure</i><br>DUE TO <i>Cerebral Vascular Thrombosis</i><br>(b) <i>Generalized Arterio-sclerosis</i><br>DUE TO<br>(c)<br>331X |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <i>10</i> a.m. <i>10</i> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19 <i>Sept 67</i> , that (I) (we) last saw the deceased alive on <i>June 1967</i> , and that death occurred at <i>GP</i> M, from causes and on the date stated above.                           |   |   |   |
| 22a. SIGNATURE<br><i>U.L. Etienne</i>   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                   | 22b. DATE SIGNED<br><i>9-14-67</i>  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>U.L. ETIENNE</i>   |   | 22d. ADDRESS<br><i>College Park, Md</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 23b. DATE THEREOF<br><i>Sept 18, 1967</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt Olivet Cemetery</i>   | 23d. LOCATION (City or Town) (County) (State)<br><i>Washington D. C.</i>                                    |
| 24. FUNERAL DIRECTOR<br><i>F. Gasch's Sons</i>  |   | 25a. REC'D BY REGISTRAR<br><i>SEP 19 1967</i>   |   |
| ADDRESS<br><i>Hyattsville, Md.</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |

RECEIVED AT THE OFFICE OF THE  
SHERIFF OF THE COUNTY OF  
LOS ANGELES, CALIFORNIA

Los Angeles  
3 pr. Colored Port Mt  
7300 Vile Ave  
JAN 14 1903  
JAN 14 1903  
JAN 14 1903  
JAN 14 1903

General  
General  
General

1903  
9-14-03  
Colored Port Mt

W. L. Etienne  
JAN 14 1903